

IDENTIFYING BARRIERS TO ELDERLY PARTICIPATION IN THE QUALIFIED MEDICARE BENEFICIARY PROGRAM

Final Report

August 23, 1994

Peter J. Neumann
Mimi D. Bernardin
Ellen J. Bayer
William N. Evans

Submitted to:

Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

Submitted by:

Project HOPE
Center for Health Affairs

Acknowledgments

This report would not have been possible without the work of Dr. Robyn Stone, who wrote the proposal for the study and who served as principal investigator for the first year of the project. We would also like to thank Ms. Leigh Ann White, who served as research assistant for the first phase of the study, and Mr. Jeff Wilensky, who provided assistance with computations in the data analysis phase. We are grateful to Mr. Keith Umbel for his programming support, and to Ms. Debbie Standifer Francis, who served as administrative assistant for the project.

We greatly appreciate the support, insights, and guidance provided by Dr. Feather Davis, our project officer at the Health Care Financing Administration. Thanks also to Ms. Carolyn Rimes at HCFA and Mr. Brad Edwards at Westat for all of their help in working with the Medicare Current Beneficiary Survey (MCBS).

CHAPTER 5: DISCUSSION

5.1	Understanding QMB Enrollment Rates	5-1
5.2	Does QMB Enrollment Lead to Higher Utilization of Services?	5-5

CHAPTER 6: OUTREACH TO LOW-INCOME SENIORS: WHAT WORKS?**KEY FINDINGS FROM FEDERAL AND STATE PROGRAMS** 6-1

6.1	Introduction	6-1
6.2	Local Social Service Outreach	6-2
6.3	Outreach for Federal Programs	6-4
6.4	State Outreach Programs and QMB Enrollment Rates	6-24
6.5	Lessons Learned from Past Efforts	6-28
6.6	Comments from Outreach Professionals: Final Meeting of the Technical Advisory Panel	6-30

CHAPTER 7: CONCLUSIONS AND IMPLICATIONS

7.1	Major Findings	7-1
7.2	Policies, Implications	7-1
7.3	Areas for Further Research	7-2

REFERENCES R-1**APPENDICES**

Appendix A: Exploring the Accuracy of the Sample	A-1
Appendix B: Technical Advisory Panel Members	B-1

TABLES AND FIGURES

Table 4.1: QMB Enrollment	4-1
Table 4.2: Enrollment by Buy-In Status	4-2
Table 4.3: Demographic Characteristics	4-3
Table 4.4: Health Care Utilization	4-7
Table 4.5: Health Insurance	4-9
Table 4.6: Social Isolation	4-11
Table 4.7: Logistic Models of QMB Participation, Normalized Coefficients and Standard Errors of Logistic Models	4-13
Table 4.8: Sources of Information	4-16
Table 4.9: Reasons for Not Participating in the QMB Program	4-19
Table 4.9a: Reasons for Non-Participation by Income	4-19
Table 4.9b: Reasons for Non-Participation by Education Level	4-20
Table 6.1: Outreach for the Medicaid and QMB Programs	6-35
Table 6.2: Outreach for the SSI Program	6-38
Table 6.3: Outreach for the Food Stamps Program	6-40
Table 6.4: State Outreach Strategies	6-10
Table 6.5: Aggressiveness of QMB Outreach, by State	6-42
Table 6.6: Total of QMB Enrollment Rates: States with Aggressive vs. Non-Aggressive Outreach Strategies	6-25
Table 6.7: Effects of Outreach on QMB Participation, Normalized Logistic Coefficients and Standard Errors	6-27
Figure 2.1 QMB Benefit Timeline	2-6
Figure 3.1: Merging of Databases	3-5
Figure 4.1: Percent Enrolled in QMB by Income	4-21
Figure 4.2: Percent Enrolled in QMB by Education	4-22
Figure 4.3: Percent Enrolled in QMB by Race	4-23
Figure 4.4: Percent Enrolled in QMB by General Health	4-24
Figure 4.5: Health Care Utilization by Physician Visits	4-25
Figure 4.6: Health Insurance: Had Medicaid on 12/31/92	4-26
Figure 4.7: Health Insurance : Other Private Insurance	4-27

EXECUTIVE SUMMARY

INTRODUCTION

The Medicare Buy-In, or Qualified Medicare Beneficiary (QMB) program, was designed by Congress to protect low-income beneficiaries from some of the burden of Medicare out-of-pocket costs. Since 1990, the Medicaid program has been required to pay the Medicare premiums, deductibles, and co-payments for low-income Medicare beneficiaries meeting certain income and asset criteria. The purpose of this study was to estimate how many eligible beneficiaries were actually participating in the program, and to help develop more effective outreach strategies to increase participation rates.

The study had four primary objectives:

- 1) To produce national estimates of the size and characteristics of the eligible elderly population enrolled and not enrolled in the QMB program;
- 2) To identify the most significant barriers to program participation, and the most frequent sources of information that would facilitate outreach;
- 3) To identify local areas where nonenrollees are most likely to reside and where outreach programs should be targeted; and
- 4) To develop alternative models of outreach programs tailored to the needs and preferences of different subpopulations of poor elderly.

BACKGROUND

Since the inception of the Medicaid program in 1966, states have had the option to provide Medicaid payment of Medicare premiums and cost-sharing for individuals qualifying for both Medicare and Medicaid. By paying the Medicare premiums, states are effectively buying Medicare coverage for their poor seniors. This benefit has therefore become known as the Medicare "Buy-In" program. Beginning January 1, 1987, federal law allowed the states to provide such payments to beneficiaries meeting a state-established income standard not to exceed 100 percent of the federal poverty level (FPL), and a resource standard not to exceed the level set for SSI recipients in the state (CRS, 1988). Individuals meeting these criteria were designated as "Qualified Medicare Beneficiaries" or QMBs. The Medicare Catastrophic Coverage Act of 1988 (MCCA) mandated state Medicaid payment of Medicare premiums and deductibles for these low-income seniors. Although most of the provisions of the 1988 act were repealed, the buy-in requirements were left intact.

Over the years, Administration officials, members of Congress, and consumer groups have expressed concern that many eligible seniors were not enrolling in the QMB program, despite attempts to inform them about the benefit. One study reported that half of the low-income elderly who were eligible for the benefit were not enrolled in the program (Families USA, 1992).

Studies of other income-related government health and welfare programs have also reported low participation rates among the elderly. In particular, they have noted that barriers to participation include seniors' lack of knowledge about programs and their reluctance to participate because of the stigma of welfare. This study was designed to better understand the characteristics and motivations of enrolled and non-enrolled populations so that we can better devise and target outreach strategies.

DATA AND METHODS

This study proceeded in five stages. First, in conjunction with Westat Inc., a survey research firm, we used the Income and Assets (I&A) Supplement of the Medicare Current Beneficiary Survey (MCBS) to select a sample of Medicare beneficiaries who met QMB eligibility criteria. The I&A Supplement collects detailed information about beneficiaries' financial resources. Respondents to the survey were deemed eligible if their incomes did not exceed 100 percent of the Federal Poverty Level, and their assets did not exceed twice the amount established for SSI eligibility.

Second, with the help of a technical panel of experts, we developed and administered a supplemental questionnaire designed to gather information about the eligible population's knowledge of the QMB program, their sources of information, and, for non-enrollees, their reasons for not participating. Third, we merged the data from the QMB supplement with two other databases containing information on QMB-eligibles: one incorporating data from the MCBS on beneficiaries' socioeconomic and demographic characteristics, health insurance, health utilization, health status, and family support network; and the other containing information from HCFA's "Buy-In" File, which was used to verify if eligible beneficiaries were actually enrolled in the program. Fourth, we used this comprehensive database to predict describe the enrolled and nonenrolled population and, through logistic regression, to predict QMB participation. Finally, we applied our results to small area data to identify those geographic areas likely to have the largest proportion of non-participating eligible beneficiaries.

RESULTS

Our analyses indicated that 41 percent of eligible beneficiaries were enrolled as Medicare Buy-Ins. Nationally, this translated to 1.93 million enrolled out of 4.67 million eligible.

Socioeconomic and Demographic Characteristics

Women, who comprised 73 percent of the eligible population, had higher enrollment rates (44 percent) than men (35 percent). Enrollment rates did not seem to vary greatly with age, though they were slightly higher for the oldest beneficiaries.

Enrollment rates fell steadily as education level rose. Those with a first grade or lower education had enrollment rates of 69 percent, for example, while those with college experience had rates of 25 percent. Enrollment rates were slightly higher for those with lowest incomes, though rates varied considerably with income levels.

Married beneficiaries had lower enrollment rates (30 percent) than widowed (42 percent), divorced (58 percent), separated (52 percent), or never married beneficiaries (55 percent). Whites, who comprised almost 70 percent of the sample, had the lowest enrollment rates (37 percent). Asian Americans had the highest rates (68 percent), followed by African Americans (51 percent) and Native Americans (48 percent).

Beneficiaries living in non-metropolitan areas (31 percent of the sample) had slightly higher enrollment rates (44 percent) than those living in metro areas (40 percent). Enrollment rates were highest in the South (49 percent), followed by the West (41 percent), the Midwest (37 percent), and the Northeast (36 percent). Results of the mapping component of our analysis are described in Appendix C, to be presented under separate cover.

Health Status, Health Utilization, and Health Insurance

Enrollment decreased as self-reported health status improved. Approximately 50 percent of those reporting fair or poor health were enrolled, compared to enrollment rates of 43 percent among those who said their health was good and about 30 percent for those reporting very good or excellent health.

Those with greater utilization of health services (i.e., more hospital, physician and emergency room visits), had higher enrollment rates.¹ For example, those with no hospital visits during the previous year and a half (84 percent of the sample), had enrollment rates of 41 percent. Enrollment rates were higher for those with one visit (43 percent), two visits (50 percent), and three visits (52 percent). The pattern was similar for physician visits and emergency room visits where enrollment rates rose steadily with utilization of services.

Forty-five percent of the sample indicated that they had Medicaid at the end of 1992. Enrollment rates were much higher for those with Medicaid (88 percent) than those without

¹ On each round, respondents were asked whether they had any hospital (physician, ER) visits since the previous round. The utilization variables in Table 4.4 simply count these responses for rounds 1 through 4. Thus, there is a maximum of four visits.

(4 percent). Enrollment rates were very high (95 percent) among the 29 percent of respondents who indicated that they were recipients of SSI. Enrollment rates were over 82 percent for those receiving other welfare income. About one-fourth of the sample indicated that they had other private insurance. Among this group, 12 percent were enrolled as QMBs.

Social Support

We examined two measures of social isolation: the number of times beneficiaries talked with family members during the previous two weeks; and the number of times they talked with friends during this period. Most individuals had several contacts with family members during the two weeks prior to the survey. Enrollment rates were highest for those with no contacts (47 percent) and lowest for those with the most contacts -- 15 or more (31 percent), though enrollment rates varied for groups in between these extremes. The patterns were similar for beneficiary contacts with friends during the previous two weeks. Enrollment rates were highest for the one-fourth of the sample with no such contacts (51 percent).

Predicting Enrollment: Regression Results

We used logistic regression analysis with QMB enrollment as the dependent variable to predict QMB enrollment. Controlling for other variables, females had significantly higher enrollment rates (by about 12 percentage points) than males. Those with less education had significantly higher enrollment rates. For example, those with less than six years of education had enrollment rates about 20 percentage points higher than college educated eligibles. There was a small but significant negative income effect. Those with higher incomes had lower participation rates. There were also strong effects due to race. African American and Hispanic Americans had significantly higher enrollment rates than non-Hispanic whites (respectively about 10 and 16 percentage points higher). Measures of geographic location were also strong and significant. Western and Southern states had much higher enrollment rates than did Eastern states.

A second model of QMB participation showed that those with one or more limitations in activities of daily living (ADL) had higher enrollment rates than those with no such limitations. When we added measures of QMB outreach activities to the model, we found that as the number of outreach programs in a state increased, QMB participation increased.

Sources of Information

About half of eligibles reported that they received information about Medicare in the mail from the government. For those who said they did receive information, most said the words were easy to understand (73 percent) and that the words were printed large enough (88 percent).

Very few eligibles (7 percent) had ever heard of the QMB program. Enrollment

rates were higher for those who had heard of the program (60 percent) compared to those who had not (40 percent). Only 5 percent of eligibles said that they were enrolled as QMBs. Of this group, 94 percent were, in fact, enrolled. Of the 6 percent who said that they were not enrolled, 19 percent actually were. Of the 88 percent who did not know whether they were QMBs, almost 40 percent were enrolled. Finally, only 12 percent of respondents said that they had applied for the QMB program (and 39 percent of these were enrolled).

Reasons for Nonparticipation

Finally, non-enrollees gave a number of reasons for not participating in the program. Most non-enrollees said that they did not need it (33 percent), or that they did not think they qualified (27 percent). Sixteen percent of respondents said that they did not know about it. Other frequently provided responses were that it was too much trouble (7 percent), they just didn't do it (3 percent), and that they didn't want welfare (3 percent).²

The percentage of respondents saying that they did not believe they qualified rose with income. The percentage who didn't know about the program fell with income, from 17 percent in the lowest income category to 10 percent in the highest category. Those with lowest incomes were most likely to say that it was too much trouble or that they could not get out to enroll. The percentage of those responding that they did not qualify for the program rose with education -- from 27 percent for those with an eighth grade or lower education to 39 percent for those with at least some college education. The percentage saying that they did not know about the program fell with level of education, from 16 percent for those in the lowest category to 12 percent for those in the highest. Those with the least education were most likely to respond that it was too much trouble or that they could not get out to sign up.

DISCUSSION

Several key findings emerged from our analyses. First, many eligible beneficiaries still were not enrolling in the QMB program. According to our estimates, as of early 1993, only 41 percent of eligibles were participating.

A second important result is that those who were enrolling were those most in need of the program. Beneficiaries with lower incomes and higher health care utilization, for example, were much more likely to participate. Among eligibles, these are the two subgroups most vulnerable to Medicare out-of-pocket costs -- lower income beneficiaries

²Note that respondents provided verbal answers to these questions, and that this categorization was developed from these responses. However, in many cases, the responses were not clear or beneficiaries gave more than one answer (e.g., saying that they did not need the program, followed by a statement noting that they did not want welfare). We classified responses based on the first statement made.

because they have less money with which to pay such expenses -- and heavy users because with each encounter with the health system, they are likely to incur additional out-of-pocket costs. Non-enrolled eligibles who are not heavy users of medical services are less burdened with deductibles and co-payments (though they are still assessed a monthly Part B premium (\$41.10 in 1994).³

Participation also was higher among those with less education and with fewer social contacts. For example, beneficiaries with less than a sixth grade education were much more likely to participate than were those who had completed high school. Those more socially isolated (e.g., those with no contacts with friends or family members during the previous two weeks) had higher enrollment. Widowed, divorced, or never married individuals were more likely to enroll than were married beneficiaries. Those who lived in rural areas and those living farther from their usual source of care had higher enrollment rates.

In addition, those participating in other public assistance programs were much more likely to be enrolled as QMBs. For example, enrollment was very high among dual eligibles -- those who qualified for Medicare and Medicaid. Over 87 percent of those indicating they received Medicaid were enrolled, as were over 95 percent of SSI recipients. Over 81 percent of those receiving welfare income were enrolled, as opposed to 32 percent among those who were not receiving such income. These results were consistent with other findings (see chapter 2) that participation in one public program increases the likelihood of participation in another.

The fact that those most in need of the program were enrolling seems consistent with our survey findings that most non-enrollees believed that they did not need or did not qualify for the program. The reasons non-enrollees most often provided for not participating in the program were that they did not need it (33 percent) or that they did not think they qualified (27 percent). Moreover, those with higher incomes and those with more family support (e.g., those living with others in their households) were even more likely to give these responses.

These positive aspects should not detract from some basic troubling conclusions. Almost half of those with incomes under \$1,000 were not participating in the QMB program. Many eligible non-enrollees were incurring sometimes large out-of-pocket costs associated with hospital and physician visits. Less than half of those with at least one hospital visit (and its associated \$696 deductible) during the previous 18 months were enrolled. Moreover, we do not know how many nonenrollees avoided care in the first place because of requisite cost-sharing provisions.

The data also revealed that 25 percent of eligibles had other private insurance -- despite the fact the QMB program was designed to cover most of their out-of-pocket

³Beneficiaries may have other out-of-pocket expenses for items such as prescription drugs.

insurance needs.⁴ Furthermore, 12 percent of those with other private insurance were enrolled as QMBs -- which may indicate that they were paying for duplicate coverage.

Data from the QMB Supplemental questionnaire shed light on barriers to enrollment. Most beneficiaries were not well-informed about the Medicare program in general and the QMB program in particular. Only half responded that they received Medicare information in the mail from the government, and only 70 percent of these respondents reported that the words were easy to understand. Only 7 percent of eligibles had ever heard of the QMB program, and of the 91 percent who had not, almost 40 percent were actually enrolled in the program. These results show that information dissemination through mass mailings can be ineffective; the findings also underscore the need for targeted outreach programs to inform low-income seniors about the benefit.

In general, our findings were consistent with other studies that have reported low participation in income-related government programs. Studies have found that only 54 to 61 percent of the elderly population who are eligible for SSI enroll in the program (Lewin/ICF, 1989). It is interesting to speculate on why QMB enrollment rates appear to be even lower than SSI enrollment rates. One reason may be that the QMB program is newer, and therefore, it will take more time to educate beneficiaries. Another is that the income threshold for QMB eligibility is higher than those for other programs, and therefore, a greater proportion of individuals believe themselves to be ineligible. A third possibility is that methodological differences in estimating procedures were responsible for at least some of the discrepancy.

The survey results on reasons for nonenrollment were also interesting. The results were consistent with other research findings that informational barriers are an important reason for low enrollment. Louis Harris and Associates (1987) reported that among those who were eligible but not participating in the SSI program, 43 percent of eligibles believed themselves to be ineligible, and another 43 percent were unsure of their status. Coe (1983) found that informational barriers to the receipt of Food Stamps were very significant; more than 40 percent of those meeting the eligibility criteria did not think they were entitled to the benefit.

Our results indicated that lack of knowledge about the program was the most significant barrier for about 45 percent of non-enrollees (including those who said they did not believe they qualified (27 percent); those who did not know about the program (16 percent), and those who didn't know how to enroll (1 percent).

⁴Unfortunately, we do not know what services are covered by this other private insurance. Some may include coverage of services not included in the QMB program -- prescription drugs, for example.

We found that while enrollment rates tended to be higher among those with lower incomes and less education, nonenrolled individuals of this group were more likely to report that they didn't know about the program, that it was too much trouble, or that they could not get out to get it. We noted, though, that overall, lack of mobility did not seem to be a major problem. In fact, informational barriers seemed much more important than physical barriers for our population. Only 7 percent of the nonenrollees reported that their primary reason for not enrolling was that it was too much trouble, and only one percent said their primary reason was lack of mobility.

Moreover, compared to other studies, a higher percentage of respondents in our study (33 percent) reported that they did not need the program. There may be two reasons for this: First, as mentioned above, our population included individuals with higher incomes than programs covered in other studies such as SSI or Food Stamps. Second, we categorized responses according to the first verbal reply recorded from the survey. Some individuals who said that they did not need the QMB program went on to report other reasons such as that they did not want welfare. Therefore, part of our result may be attributable to our methodology.

OUTREACH TO LOW-INCOME SENIORS: WHAT WORKS?

In planning outreach projects, it is helpful to examine the many federal, state, and private initiatives that have sought to increase enrollment of low-income senior citizens in public benefits programs. Based on the information available, it is difficult to draw absolute conclusions about appropriate outreach strategies, as most outreach projects have not been rigorously evaluated. Descriptions of project outcomes, when available, are often anecdotal, lacking specific data to support general conclusions. Even when data are provided, critical information (such as the percentage of those eligible for benefits who applied and enrolled before, during, and after implementation of the outreach programs) is often missing.

As part of this project, we examined the effect of state QMB outreach programs on QMB enrollment. Our regression results suggested that the states that tried a number of different outreach strategies had the highest QMB participation rates.

Despite the limitations of the available data, it is possible to make some basic generalizations:

- It is often difficult to enroll low-income seniors in public benefits programs.
- Communication with low-income groups should not be limited to mass media campaigns.

- Outreach is most effective when narrowly targeted to specific low-income subpopulations.
- Grass-roots organizing and interpersonal contacts tend to work well.
- Helping those potentially eligible through the enrollment process can be critical.
- "Outstationing" can help remove stigma.
- Several concurrent strategies may most effectively increase program participation.

These findings suggest that effective outreach is necessarily quite labor-intensive and expensive. To help policymakers make difficult decisions about resource allocation in an era of tight budget constraints, future outreach projects should examine issues of cost-effectiveness as well as efficacy.

CONCLUSIONS AND IMPLICATIONS

The study led to several important conclusions:

1. Many eligible beneficiaries still are not enrolled in the QMB program.
2. Those who are enrolled tend to be those most in need of the program.
3. Nonparticipating eligibles are not enrolling because they are not aware of the program or their own eligibility for it, or because they do not believe they need the program.
4. Outreach programs seem to be most effective when they use a number of different strategies, including interpersonal contacts, enrollment assistance, and grass roots community organizing.

Identifying and enrolling eligible individuals is a problem common to all means-tested government assistance programs. Legislating that certain individuals are eligible does not ensure their participation. Even with the most aggressive outreach efforts, it is difficult to reach all eligible individuals. Many individuals do not receive or comprehend outreach information. Some who suspect they are eligible have trouble accessing the system because of program complexities. Others refuse to enroll because of the stigma of welfare. These results underscore the need for aggressive outreach strategies and follow-up efforts. Ideally, these approaches should involve several ongoing activities with information targeted to those most in need.

CHAPTER 1

INTRODUCTION

The Medicare Buy-In, or Qualified Medicare Beneficiary (QMB) program, was designed by Congress to protect low-income beneficiaries from some of the burden of Medicare out-of-pocket costs. Since 1990, the Medicaid program has been required to pay the Medicare premiums, deductibles and copayments for low-income elderly beneficiaries and other disabled Medicare enrollees meeting certain income and asset criteria. Early studies reported, however, that about half of those eligible for the program were not participating (Families USA, 1991). The purpose of this study is to better understand who is enrolling and why, and to provide information that could be used to develop more effective outreach strategies.

The study has four primary objectives:

- 1) To produce national estimates of the size and characteristics of the elderly subpopulations enrolled and not enrolled in the QMB program;
- 2) To identify the most significant barriers to program participation, and the most frequent sources of information that would facilitate outreach;
- 3) To identify local areas where nonenrollees are most likely to reside and where outreach programs should be targeted; and
- 4) To develop alternative models of outreach programs tailored to the needs and preferences of different subpopulations of poor elderly.

In Chapter Two of this report we provide a brief history of the QMB program and a discussion of some of the problems typically encountered when enrolling individuals in means-tested government programs. Chapter Three describes the data and methods employed in this study. Chapter Four presents the study results, and Chapter Five discusses the

implications of our findings. Chapter Six reviews a variety of outreach strategies which have sought to increase participation in the QMB program, as well as in programs such as Medicaid, Supplemental Security Income, and Food Stamps. The final chapter provides conclusions and discusses areas for further research.

CHAPTER 2

BACKGROUND

2.1 Description of the Medicare Buy-In Program

Since the inception of the Medicaid program in 1966, states have had the option to provide Medicaid payment of Medicare premiums and cost-sharing for dually-eligible Medicare beneficiaries (i.e., individuals qualifying for both Medicare and Medicaid). In January 1, 1987, federal law gave the states the option to provide such payments to beneficiaries meeting a state-established income standard not to exceed 100 percent of the federal poverty level (FPL), and a resource standard no. to exceed twice that set for Supplemental Security Income (SSI) recipients in the state (CRS, 1988). The Medicare Catastrophic Coverage Act of 1988 (MCCA) *mandated* state Medicaid payment of Medicare premiums and deductibles for low-income "qualified Medicare beneficiaries" (QMBs). Although most of the provisions of the 1988 act were repealed, the buy-in requirements were left intact.

The Omnibus Reconciliation Act (OBRA) of 1990 sped up enactment of the MCCA QMB provisions and expanded the program. Specifically, it required that Medicare beneficiaries with incomes up to 100 percent of the poverty guideline be covered in 1993, and those with incomes up to 120 percent of the guidelines be covered in 1995. Individuals with income between 100 and 120 percent of the FPL are called Specific Low-Income Medicare Beneficiaries (SLMBs) and are covered for Medicare Part B premiums only (Families USA, 1991; HCFA, 1991). In addition to income and asset requirements, QMBs must meet the general nonfinancial requirements for medical assistance, such as filing an application for Medicaid and obtaining a Social Security number.

A QMB can qualify for Medicaid under other eligibility groups such as categorically needy or medically needy, and is entitled to have eligibility determined under all categories.

Although an individual can "spend down" to meet eligibility criteria for categorically needy or medically needy groups, "spend down" does not apply to the QMB program (HCFA, 1991).

Over the years, policymakers have been concerned that eligible seniors were not enrolling in the program. Both government and private organizations have undertaken a number of activities to increase participation, including disseminating information about the program through leaflets, newsletters, and public service announcements (see chapter 6). A study by Families USA in 1991 (and another in 1992), which relied primarily on data from the Current Population Survey (CPS), reported that over half of the 4.2 million poor elderly who were eligible for the benefit were not enrolled in the program (Families USA 1991; Families USA, 1992).

2.2 Barriers to Enrollment

It is not entirely surprising that some individuals eligible for the QMB program have not enrolled. Several previous studies have found low participation rates in other government health and welfare programs for low-income seniors. In particular, these studies have indicated that barriers to participation include seniors' lack of knowledge and a reluctance to participate because of the stigma of welfare. It is instructive to review this literature before embarking on an analysis of QMB enrollment rates.

Barriers to Welfare Program Participation

The General Population. Reasons for nonparticipation in welfare programs can vary greatly across the spectrum of financial need. Bendick (1980) described several types of voluntary nonparticipants across the income range of eligible persons. Many at the higher end of the income eligibility range voluntarily decline welfare benefits because the out-of-pocket costs (travel to the office, case processing), opportunity costs (time in enrollment process), or psychological costs (stigma) are too great. Those at the lower end of the income eligibility scale may have different reasons for not participating, most of which are out of the

eligible person's control. These problems of program accessibility--what Bendick refers to as true barriers to participation--may include transportation costs, poor reading skills or low educational level, poor mobility, lack of help from friends or family, program rigidity, bureaucratic procedures, complex application forms, and lack of skills to complete the application process.

Using data from the Panel Study of Income Dynamics, Coe (1983) constructed the following typology of barriers to participation in the Food Stamps Program: (1) informational/awareness problems; (2) problems with program parameters (amount of benefit, legislative conditions); (3) local administrative problems; (4) physical access limitations such as transportation costs, distance to the welfare office, or mobility of the individual; and (5) attitudinal factors (either the stigma effect or the feeling that one does not need the benefit). Coe found significant informational barriers to the receipt of Food Stamps; more than 40 percent of those meeting the eligibility criteria did not think they were entitled to the benefit. Despite wide publicity efforts designed to inform potential eligibles about the existence of the program, certain subgroups (e.g. the low-income, unmarried elderly) still did not believe they were eligible. Coe recommended aggressive outreach efforts which included not only informing people of the existence of the benefit, but also educating them about the nature of the programs.

Researchers have also noted that because welfare programs interact and overlap with one another, rates of participation in one program often affect participation in other programs. For example, using the 1979 Panel Study of Income Dynamics, Coe (1983) found that households already receiving other forms of welfare were more likely to use Food Stamps. These households were less likely to say they were ineligible or did not need the benefit, and were less likely to report a stigma attached to welfare.

The Elderly. Using data from the Current Population Survey and the Survey of Income and Program Participation (SIPP), researchers from Lewin/ICF found that in 1988, only 54 to 61 percent of the elderly population eligible for SSI were actually enrolled

(Lewin/ICF, 1989). Participation rates varied substantially across states. Multivariate analysis revealed that factors having a positive effect on participation included poor health status, lack of health insurance, living in the South, and participation in other subsidized programs such as Food Stamps and public housing. Limitations of the data precluded an examination of reasons for nonparticipation. Previous research by Hollenbeck and Ohls (1984) corroborates the association between receipt of SSI benefits and participation in the Food Stamps program.

Researchers at Lewin/ICF emphasized that the SIPP did not collect the data that would be necessary to determine levels of need among persons potentially eligible for SSI. Therefore, they recommended the development of a supplementary questionnaire to be administered to SIPP respondents meeting certain income criteria. Questions would collect information on knowledge about the SSI program and the application process, as well as reasons for not applying.

Louis Harris and Associates (1987) surveyed elderly persons living alone who were not receiving SSI but who had incomes low enough to be eligible. Fourteen percent believed they were eligible, but chose not to apply. Forty-three percent thought they were not eligible, and another 43 percent were unsure of their status. In a follow-up study, the organization collected information on the media habits of the low-income elderly, as well as their sources for advice and assistance (Louis Harris and Associates, 1987). The majority of respondents reported television as their primary media source (66%); for persons on SSI, the percentage was even greater (81%). For advice about problems, most sought out their physician or other health care professional. Family members and clergy were also identified as key sources.

Chapter Six provides an overview of outreach programs which have sought to overcome barriers to enrollment in SSI, QMB/Medicaid, and Food Stamps.

2.3 Policy Significance

HCFA officials have explored a variety of strategies for increasing participation in the QMB program. To develop such strategies, it is first necessary to gather more detailed information about eligible nonparticipants, including their geographic location and the reasons for nonenrollment. The objective of this project is to provide this information to help facilitate the implementation of future outreach efforts.

The Families USA study provides gross estimates of the number of elderly people who are eligible but not enrolled in the QMB program. The accuracy of these estimates is subject to question, however, as they were derived by combining information from several secondary data sources, including a pooled data base of four years of the March Current Population Survey, the 1984 Survey of Income and Program Participation, and the State Buy-in Master File produced by HCFA's Bureau of Data Management and Strategy.

An analysis of person-level data from a national probability sample of noninstitutionalized Medicare enrollees participating in the Medicare Current Beneficiary Survey (MCBS) provides a more complete and precise estimate of the magnitude of the problem, and furthers our understanding of the reasons why individuals are not participating in the program. Our analyses identify the most important sociodemographic characteristics (e.g., age, gender, race, geographic region, economic status), and other key predictors (e.g., degree of social isolation, attitudes toward welfare programs, and state variation in outreach activities) that will help in targeting specific subpopulations of elderly Medicare enrollees.

This project has also produced detailed maps identifying areas where eligible nonenrollees are most likely to reside. These maps are included in Appendix C, to be submitted to HCFA under separate cover. Finally, the project describes strategies which can be used in the development of an aggressive QMB outreach campaign.

QMB Benefit Timeline

Legislation	Social Security Amendments: Medicaid Begins	OBRA 1986	MCCA 1988	MCCA 1988	OBRA 1990	OBRA 1990	OBRA 1990	
Effective Date	1966	1987	1989	1990	1991	1992	1993	1995
Provision	State Option	State Option	State Mandate	State Mandate	State Mandate	State Mandate	State Mandate	
	Medicare Buy-In for Medicaid recipients	Medicare Buy-In or full Medicaid benefits to those with incomes <=100% FPL and assets <=200% SSI (QMBs)	Medicare Buy-In to those with incomes <=85% FPL and assets <=200% SSI	Increase income threshold to 90% FPL	Increase income threshold to 100% FPL	Medicare Part B Premium to those with incomes between 100% and 110% FPL (SLMBs)	Increase SLMB income threshold to 120% FPL	
QMB Study Activities					CBS begins	QMB Sample drawn from CBS I&A Supplement	QMB Supplement Fielded from CBS I&A Supplement	

CHAPTER 3

DATA AND METHODS

3.1 Overview

The data collection and analysis proceeded in five steps. First, using the Income and Assets Supplement of the Medicare Current Beneficiary Survey (MCBS), we identified a sample of beneficiaries who met QMB eligibility criteria. Second, we developed and administered to this population of eligible beneficiaries an additional questionnaire, the "QMB Supplement," which contained questions probing respondents' knowledge of the QMB program and their sources of information. Third, we merged the data from the QMB supplement with two other databases: one containing detailed information from other rounds of the CBS on beneficiaries' demographic and socioeconomic characteristics, and the other containing information from HCFA's "Buy-In" file, which was used to verify if beneficiaries were actually enrolled in the program. Figure 3.1 provides a schematic diagram of our approach. Fourth, we conducted univariate analyses to describe the eligible population and an individual's tendency to enroll in the QMB program based on his or her characteristics. We also developed regression models to predict QMB participation. Finally, we applied the results to small area data to identify those geographic areas likely to have the largest proportion of nonparticipating eligible beneficiaries.

3.2 Identifying a Sample of QMB Eligibles

The Medicare Current Beneficiary Survey

The Medicare Current Beneficiary Survey, sponsored by the Health Care Financing Administration, is a continuous, multi-purpose survey designed to enable researchers to examine the current status of the Medicare population and the impact of proposals to change Medicare policy (Stone, 1993). The CBS consists of a series of interviews conducted three

times a year with a stratified random sample of aged and non-aged Medicare beneficiaries, focusing on health care utilization and expenditures over time. The survey also collects information on demographic characteristics, financial resources, health insurance coverage, health status, living arrangements, and family support.

The survey involves a nationally representative sample of elderly and nonelderly Medicare beneficiaries. The initial sample, fielded in September 1991 and completed in December 1991, consisted of 14,530 individuals for whom 12,677 interviews were completed. Sampled individuals have been interviewed three times a year over several years to develop a profile of their health care experiences over time. Supplemental questionnaires are fielded in each round of the MCPS, focusing on special topics such as beneficiaries' access to care.

The MCBS is a particularly useful tool for an analysis of the QMB population, due to the comprehensive scope of the data collected and its flexibility for incorporating supplemental questions for selected populations. In particular, the Income and Assets (I&A) Supplement, fielded in the summer of 1992 (and again in the summer of 1993) is useful in identifying a sample of eligible beneficiaries.

The CBS Income and Asset Supplement

The Income and Asset (I&A) Supplement of the MCBS was designed to collect detailed information about beneficiaries' financial resources. Beneficiaries were asked about sources of income, including income from Social Security, employment, Supplemental Security Income (SSI), public assistance, Food Stamps, retirement funds, rental properties, interest from bank accounts, and dividends from stocks and other investments. Questions about assets included queries about the value of beneficiaries' stocks, life insurance, home, automobile, and property.

Working with Westat, Inc, a survey research firm, we used information from the I&A Supplement to determine if beneficiaries were eligible for the QMB program. Respondents were deemed eligible if their incomes did not exceed 100 percent of the federal poverty level, and their assets did not exceed twice the amount established for SSI eligibility.¹ If respondents did not provide responses to all of the questions, eligibility was determined on the basis of responses to other relevant questions. For example, if respondents with incomplete income and asset information indicated elsewhere that they received public assistance, they were considered QMB-eligible. In total, some 1500 beneficiaries in the MCBS sample were identified as eligible for the program.

3.3 Developing and Administering the QMB Supplemental Survey

In April 1992, Project HOPE convened a technical advisory panel comprised of staff from the Health Care Financing Administration and representatives from consumer organizations that had conducted community outreach programs in communities with large numbers of low-income elderly. A list of panel members is provided in Appendix B. The panel discussed findings from the Families USA study on QMB enrollment, reviewed outreach efforts to increase program participation, and contributed their ideas on the development of the QMB supplemental questionnaire.

The QMB supplement to the MCBS was designed to gather information about the eligible population's knowledge of the QMB program and their sources of information. In particular, the questionnaire asked respondents:

- whether they had received information about the Medicare program;
- whether the words were easy to understand;
- how they preferred to receive information about the Medicare program;
- whether they had heard of the QMB program;

¹Income and asset standards may vary somewhat state, as discussed in Chapter 2.

- whether they were enrolled in the QMB program;
- how they had learned about the QMB program;
- why they did not enroll in the QMB program;
- whether they had received help in the application process; and
- whether they had applied for other low-income programs.

In addition, to gather information on social isolation, the questionnaire asked respondents about the extent to which they communicated with friends and family and about their means of transportation.

3.4 Merging the Databases

To provide additional information on our sample of eligible individuals, we merged two other databases with the data from the QMB supplement. One file contained detailed information from other rounds of the MCBS on a wide range of socioeconomic and demographic characteristics, as well as information about beneficiaries' health insurance, health utilization, health status, and family support network. Finally, we matched our sample to HCFA's Buy-In File, which contains information on beneficiaries for whom state Medicaid programs are paying Part B Medicare premiums and other cost-sharing provisions. The Buy-In file could thus be used to verify whether eligible beneficiaries were actually enrolled in the program.

3.5 Statistical Methods

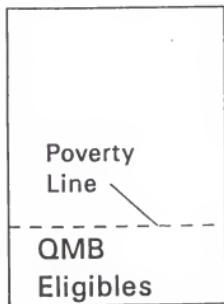
We used univariate analyses to describe the entire QMB-eligible population: their socioeconomic and demographic characteristics; health insurance coverage and health care utilization; self-reported health and functional status; level of social isolation; general sources of information; and knowledge of the QMB program. We also described the likelihood of QMB enrollment for each individual characteristic. To predict QMB participation, we developed several logistic regression models with QMB enrollment as the dependent variable.

Step 1
Identify QMB
Eligibles

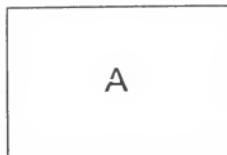
Step 2
Administer
QMB
Supplement

Step 3
Merge Data
Bases

CBS Income and
Asset Supplement



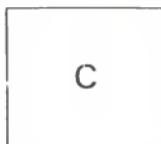
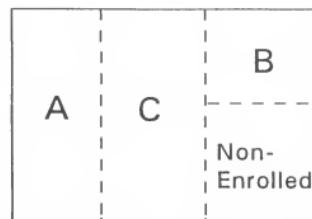
QMB
Supplement



TPIB Buy-In



MERGED
FILE



CBS General Subset

A = QMB Supplement

B = Subset of Eligibles Who
Are Enrolled

C = CBS General

CHAPTER 4

RESULTS

4.1 QMB Enrollment

Our analyses indicate that 41.3 percent of eligible beneficiaries are enrolled as Medicare Buy-Ins. Nationally, this translates to 1.93 million enrolled out of 4.67 million eligible. The results are shown in Table 4.1.

Table 4.1: QMB Enrollment

Eligibles	4.67 million	100%
Enrolled	1.93 million	41%
Not Enrolled	2.74 million	59%

Table 4.2 provides a further breakdown of these numbers by Medicaid eligibility status. The table shows that 50 percent of enrollees are designated recipients of Supplemental Security Income (SSI); 33 percent are designated "QMBs," while another 8 percent are coded as receiving supplemental payments from their states. Since all of these beneficiaries are supposedly eligible for the QMB program, theoretically, they should all be designated as QMBs -- i.e., Medicaid should be paying all of their cost-sharing provisions (premiums, deductibles, and co-payments). However, only one-third of eligibles are so designated. It appears from Table 4.2 that only one-third of eligibles have all of their cost-sharing paid for by Medicaid, while the other two thirds have their Part B premiums paid.

Table 4.2: Enrollment by Buy-In Status

Codes	Description	Percent
A, B, D	Supplemental Security Income (SSI) Recipients (Aged, Blind, and Disabled)	50%
P	(QMB) Qualified Medicare Beneficiary	33%
E, G	Supplemental Payment Recipients (Aged and Disabled)	8%
Z	Deemed categorically needy (state to HCFA)	2%
M	Entitled to Medical Assistance Only (MAO), non-cash recipient (state to HCFA)	2%
K, S, V	Other	6%
Total		100%

Part of the problem might be due to coding inconsistencies among states (Sparacino, 1994). Thus, all we know for sure is that 41 percent of eligibles have their Part B Medicare premiums paid for by the state and are designated by the more general term, "Medicare Buy-Ins."

4.2 Description of QMB Eligibles and Their Tendency to Enroll

Tables 4.3 through 4.6 show the results of our descriptive analyses. In all of the tables, the data are similarly presented: the left side describes the entire eligible population (columns add to 100 percent), and the right side describes the likelihood of QMB enrollment by each variable (rows add to 100 percent).

Demographic Characteristics

Table 4.3 describes the characteristics of the QMB-eligible population and their tendency to enroll in the program. We review the highlights below and present some of the

Table 4.3: Demographic Characteristics

	Percent of Eligibles	Tendency to Enroll	
		Enrolled	Non Enrolled
Gender			
Male	27%	35%	65%
Female	73%	44%	57%
Age			
45 - 64	1%	35%	65%
65 - 74	48%	42%	58%
75 - 84	38%	40%	60%
85+	13%	43%	57%
Marital Status			
Married	28%	30%	70%
Widowed	53%	42%	58%
Divorced	9%	58%	42%
Separated	3%	52%	48%
Never Married	6%	55%	45%
Number of Living Children			
0	14%	41%	59%
1	16%	35%	66%
2	18%	36%	64%
3	15%	37%	63%
4	12%	33%	67%
5 or more	25%	57%	43%
Hispanic Origin			
Yes	15%	47%	53%
No	85%	40%	60%
Race			
Native American	1%	48%	52%
Asian	3%	68%	32%
African American	22%	51%	49%
White	69%	37%	63%
Other	4%	43%	57%

Table 4.3: Demographic Characteristics (Cont'd)

	Percent of Eligibles	Tendency to Enroll	
		Enrolled	Non Enrolled
Education			
1st or less	6%	69%	31%
2nd - 5th	19%	53%	47%
6th - 8th	28%	44%	56%
9th - 11th	19%	36%	64%
12th	18%	29%	71%
1-3 years college	6%	23%	77%
4 or more years college	3%	26%	74%
Income (\$)			
< 1,000	68%	48%	52%
1,000 - 1,900	9%	12%	88%
2,000 - 3,999	3%	12%	88%
4,000 - 5,999	6%	47%	54%
6,000 - 7,999	3%	36%	64%
8,000 - 9,999	1%	28%	72%
Geographic Location			
Metro	69%	40%	60%
Non-Metro	31%	44%	56%
Region			
Northeast	18%	36%	64%
Midwest	15%	37%	63%
South	45%	49%	52%
West	22%	41%	59%
General Health			
Excellent	13%	30%	71%
Very Good	20%	29%	71%
Good	29%	43%	57%
Fair	26%	52%	48%
Poor	13%	48%	53%

characteristics graphically in Figures 4.1 through 4.4, which are included at the end of the chapter.

Gender. Women, who comprise 73 percent of the eligible population, have higher enrollment rates (44 percent) than men (35 percent).

Age. The table indicates that enrollment rates do not seem to vary greatly with age, though they are slightly higher for the oldest beneficiaries. Enrollment rates are 42 percent for those aged 65 to 74; for those over 85, they are 43 percent.

Marital Status. Most of the eligible population is widowed (53 percent) or married (28 percent). Married beneficiaries have lower enrollment rates (30 percent) than widowed (42 percent), divorced (58 percent), separated (52 percent), or never married beneficiaries (54 percent).

Number of Living Children. Beneficiaries with five or more living children, who comprise 25 percent of the sample, have the highest enrollment rates (57 percent).

Race. Whites, who comprise almost 70 percent of the sample, have the lowest enrollment rates (37 percent). Asian Americans have the highest rates (68 percent), followed by African Americans (51 percent) and Native Americans (48 percent).

Education. Enrollment rates fall steadily with level of education. Those with a first grade education or less have enrollment rates of 69 percent, for example. In contrast, the population with at least some college experience has a 25 percent enrollment rate.

Income. Enrollment rates are slightly higher for those with lowest incomes, though rates vary considerably with income levels. For example, those with incomes under \$1,000 (68 percent of the sample) have enrollment rates of 48 percent, while those with incomes between \$1,000 and \$2,000 have rates of under 12 percent. For the relatively few

beneficiaries with incomes between \$8,000 and \$10,000, enrollment rates are 28 percent.

Note that reported income was taken from round 6 of the MCBS. A discussion of the accuracy of this variable is provided in Appendix A.

Geographic Location. Beneficiaries living in non-metropolitan areas (31 percent of the sample) have slightly higher enrollment rates (44 percent) than those living in metro areas (40 percent).

Region. Enrollment rates are highest in the South (49 percent), followed by the West (41 percent), the Midwest (37 percent), and the Northeast (36 percent).

General Health. Those responding that they were in excellent health (30 percent) or very good health (29 percent) have lower enrollment rates than those who said that their health was good (43 percent), fair (52 percent), or poor (48 percent).

Health Care Utilization

Table 4.4 shows enrollment by key health utilization variables. The table indicates that those with greater utilization of health services (i.e., more hospital, physician and emergency room visits), have higher enrollment rates.¹

Hospital Visits. Those with no hospital visits during the previous year and a half (84 percent of the sample), have enrollment rates of 41 percent; enrollment rates are higher for those with one visit (43 percent), two visits (50 percent), and three visits (52 percent).

¹On each round, respondents were asked whether they had any hospital, physician, or emergency room visits since the previous round. The utilization variables in Table 4.4 simply count these responses for rounds 1 through 4. Thus, for any individual, there is a maximum of 4 visits.

Table 4.4: Health Care Utilization

	Percent of Eligibles	Tendency to Enroll	
		Enrolled	Non Enrolled
Hospital Visits*			
0	84%	41%	59%
1	13%	43%	57%
2	3%	50%	50%
3	1%	52%	48%
Physician Visits*			
0	14%	27%	73%
1	11%	33%	67%
2	15%	33%	67%
3	21%	45%	55%
4	39%	50%	50%
Emergency Room Visits*			
0	66%	35%	65%
1	23%	53%	47%
2	8%	59%	41%
3	2%	44%	56%
4	0%	71%	29%
Mammography Last Year (4)			
Yes	15%	37%	63%
No	58%	45%	55%
Inapplicable	26%	35%	65%
Pap Smear Last Year (4)			
Yes	13%	37%	63%
No	60%	45%	55%
Inapplicable	26%	35%	65%
Flu Shot For Last Winter (4)			
Yes	37%	42%	59%
No	62%	41%	59%

* Maximum of one per round

(4) = Round 4 of CBS

Physician Visits. The pattern is similar for physician visits. Enrollment rates rise steadily with utilization of physician services. Those with no visits have average rates of 27 percent, compared to those with one visit (33 percent), two visits (33 percent), three visits (45 percent), or four visits (50 percent). Figure 4.5 graphs these results.

Emergency Room Visits. Enrollment rates also rise monotonically with the number of emergency room visits.

We also examined enrollment rates for beneficiaries who had received certain preventive health care; specifically, services for mammography screening, Pap smears, and flu shots.

Mammography. The table indicates that about 15 percent of the sample had received a mammography exam, while 58 percent had not (for 26 percent the question was inapplicable). Enrollment rates are slightly higher for those who had *not* received mammography.

Pap Smear. The pattern was similar for Pap smears, where enrollment rates are higher (45 percent) for those who had not received the test than for those who had (37 percent).

Flu Shot. Finally, about 37 percent of the sample had received a flu shot for the previous winter, but enrollment rates are similar for those with and without the shot. We describe QMB enrollment rates for various health insurance-related variables in Table 4.5 and graphically present this information in Figures 4.6 and 4.7.

Health Care Insurance

We describe QMB enrollment rates for various health insurance-related variables in Table 4.5 and graphically present this information in Figures 4.6 and 4.7.

Medicaid. Forty-five percent of the sample indicated that they had Medicaid as of the end of 1992. Enrollment rates are much higher for those with Medicaid (88 percent) than those without (4 percent). Most of those who reported having Medicaid were able to confirm it by providing a Medicaid card.

Table 4.5: Health Insurance

	Percent of Eligibles	Tendency to Enroll	
		Enrolled	Non Enrolled
Have Medicaid on 12/31/92			
Yes	45%	88%	12%
No	55%	4%	97%
Medicaid Card Available			
Yes	35%	91%	10%
No	9%	83%	17%
Inapplicable	56%	4%	96%
Employer-Provided Insurance			
Yes	10%	10%	91%
No	90%	45%	55%
Other Private Insurance			
Yes	25%	12%	83%
No	75%	51%	49%
SSI			
Yes	29%	95%	5%
No	69%	19%	81%
Receive Welfare Income			
Yes	18%	83%	17%
No	80%	32%	68%

Employer-Provided Insurance. Most of the sample (90 percent) did not have employer-provided health insurance. Among the 10 percent of the sample with such insurance, enrollment rates are low (10 percent).

Other Private Insurance. Interestingly, about one-fourth of the sample indicated that they had other private insurance (despite the fact that the QMB program should be providing for most of their cost-sharing provisions). Among this group, 12 percent were enrolled as QMBs.

Supplemental Security Income (SSI). Enrollment rates are very high (95 percent) among the 29 percent of respondents who indicated that they were recipients of SSI.

Social Isolation

Table 4.6 contains information on two measures of social isolation: the number of times beneficiaries talked with family members during the previous two weeks and the number of times they talked with friends during this period.

Talked With Family. The table indicates that most of the sample had several contacts with family members during the two weeks prior to the survey. Enrollment rates are highest for those with no contacts (47 percent) and lowest for those with the most contacts -- 15 or more (31 percent), though enrollment rates vary for groups in between these extremes.

Talked With Friends. The patterns were similar for beneficiary contacts with friends during the previous two weeks. Enrollment rates are highest for the one-fourth of the sample with no such contacts (51 percent).

Table 4.6: Social Isolation

	Percent of Eligibles	Tendency to Enroll	
		Enrolled	Non Enrolled
Talked with Family in Past 2 Weeks			
0	16%	47%	53%
1	6%	46%	54%
2	11%	37%	63%
3 - 5	14%	40%	60%
6 - 13	17%	36%	64%
14	24%	45%	55%
15 or more	13%	31%	69%
Talked with Friends in Past 2 Weeks			
0	25%	51%	49%
1	6%	38%	62%
2	9%	26%	74%
3 - 5	15%	36%	64%
6 - 13	17%	38%	62%
14	21%	43%	57%
15 or more	8%	32%	68%

4.3 Predicting Enrollment: Regression Results

We developed several logistic regression models to predict QMB program participation. The dependent variable for each model is QMB enrollment. The basic model includes measures of demographic and socioeconomic independent characteristics, and measures of health status, urbanicity and region. A second model adds a functional status measure to the basic model, and a third model includes a measure of health care access--distance to usual source of care. We try to capture the effect of state QMB outreach

activities on QMB participation in four additional models; these are presented and discussed in Chapter 6.

Table 4.7 shows the results of the first three logistic regression models. The coefficients have been transformed to show the normalized marginal effects. As indicated in the table the basic regression (Model 1) shows that after controlling for other variables, females have significantly higher enrollment rates (about 11 percentage points) than males. Those with less education have significantly higher enrollment rates. For example, those with less than six years of education have enrollment rates about 20 percentage points higher than college educated eligibles. There is a small but significant negative income effect. Those with higher incomes have lower participation rates.

There are also strong effects due to race. African Americans and Hispanic Americans have significantly higher enrollment rates than whites (respectively, about 10 and 16 percentage points higher). The regional effect is strong and significant. Western and southern states have much higher enrollment rates compared to eastern states (respectively, about 25 and 21 percentage points higher). Midwestern states have enrollment rates 12 percentage points higher.²

Age does not seem to exert an independent effect. Married individuals have significantly lower enrollment rates compared to those who are divorced or separated. Health status has a strong effect. Those in excellent or good health have significantly lower enrollment rates. Finally, home ownership shows an interesting pattern: those owning their

²However, the regional variation in QMB participation rates was greatly reduced once we added county-wide measures of wealth to the regression model. We used two variables from the Area Resource File (ARF): the natural log of per capita income in the county and the number of doctors per capita in the county. When added individually to the model, both variables were negative and statistically significant and decreased the strong regional effects. These results may indicate that the strong regional coefficients in the basic model simply reflect regional variation in income and wealth.

Table 4.7: Logistic Models of QMB Participation
 Normalized Coefficients and Standard Errors of Logistic Models (a)

Variable Type	Variable Name	Model (1)	Model (2)	Model (3)
	Intercept	0.498 (-0.718)	-0.013 (0.069)	0.284 (-1.412)
a. Demographic Characteristics	Female	0.115*** (0.039)	0.114*** (0.040)	0.117*** (0.040)
	Age in years	-0.012 (0.036)	0.002 (0.034)	-0.012 (0.036)
	Age Squared	0.000 (0.000)	-0.000 (0.000)	0.000 (0.000)
	Black (b)	0.101*** (n nzo)	0.100** (0.039)	0.102*** (0.039)
	Hispanic (b)	0.156*** (0.054)	0.164*** (0.055)	0.152*** (0.055)
b. Family Characteristics	Other Race (b)	0.145** (0.060)	0.137** (0.061)	0.143** (0.060)
	Have no living children (c)	-0.216*** (0.060)	-0.221*** (0.060)	-0.215*** (n 060)
	Ha. a * or 2 living children (c)	-0.188*** (0.044)	-0.189*** (0.044)	-0.188*** (0.044)
	Have 3 to 5 living children (c)	-0.118*** (0.044)	-0.129*** (0.044)	-0.177*** (0.044)
	Married (d)	-0.216*** (0.053)	-0.229*** (0.054)	-0.218*** (0.053)
	Never Married (d)	0.138* (0.082)	0.134 (0.082)	0.138* (0.083)
	Widowed (d)	-0.177*** (0.048)	-0.177*** (0.048)	-0.172*** (0.048)
c. Education, income and wealth	Have < = 6 years of education (e)	0.197*** (0.064)	0.198*** (0.064)	0.196*** (0.064)
	Have 7-8 years of education (e)	0.100 (0.065)	0.100 (0.065)	0.100 (0.065)
	Have 9-11 years of education (e)	0.030 (0.066)	0.027 (0.066)	0.029 (0.066)
	Have 12 years of education (e)	-0.009 (0.066)	-0.007 (0.069)	-0.008 (0.066)
	In (Family Income)	0.030 (0.019)	-0.033* (0.019)	-0.030 (0.019)
	Own home (f)	-0.223*** (0.040)	-0.213*** (0.040)	-0.221*** (0.040)
	Rent home (f)	0.160*** (0.040)	0.168*** (0.040)	0.161*** (0.040)

Table 4.7 (Cont'd)
 Logistic Models of QMB Participation
 Normalized Coefficients and Standard Errors of Logistic Models (a)

Variable Type	Variable Name	Model (1)	Model (2)	Model (3)
d. Health Status	Excellent health status (g)	-0.169*** (0.061)	-0.112* (0.063)	-0.165*** (0.061)
	Very good health status (g)	-0.211*** (0.055)	-0.157*** (0.057)	-0.206*** (0.056)
	Good health status (g)	-0.119** (0.049)	-0.075 (0.050)	-0.117** (0.049)
	Fair health status (g)	-0.003 (0.048)	0.022 (0.049)	-0.002 (0.048)
	One or more ADL's (h)		0.112** (0.051)	
	Two or more ADL's (h)		0.209*** (0.055)	
c. Other	Live in metropolitan area	-0.050 (0.037)	-0.046 (0.038)	-0.049 (0.037)
	Midwest (i)	0.118** (0.055)	0.116** (0.055)	0.117** (0.055)
	South (i)	0.251*** (0.046)	0.254*** (0.046)	0.247*** (0.046)
	West (i)	0.219*** (0.051)	0.210*** (0.051)	0.219*** (0.051)
d. Distance to Care	30 to 60 minutes (j)			0.039 (0.040)
	60 minutes or more (j)			0.022 (0.062)

* Significant at the 10% level.

** Significant at the 5% level.

*** Significant at the 1% level.

(a) The logistic coefficients and standard errors are multiplied by $p^*(1-p^*)$ where p^* is the sample mean of the dependent variable. In these models, $p^* = .4132$. The normalized coefficients are estimates of the change in the probability of enrolling in the QMB program given a change in the independent variable. All estimation procedures are weighted.

- (b) The reference category is white, non-Hispanic.
- (c) The reference category is 6 or more living children.
- (d) The reference category is divorced or separated.
- (e) The reference category is more than 12 years of education.
- (f) The reference category is living with someone else.
- (g) The reference category is poor health status.
- (h) The reference category is no ADL's.
- (i) The reference category is Northeast.
- (j) The reference category is less than 30 minutes.

homes have significantly lower enrollment rates than those who neither own nor rent (e.g., those living with children); those renting have higher enrollment rates.

The functional status measures included in Model 2 are dependency in one or more activities of daily living (ADLs) and dependency in two or more ADLs. The model shows that those with one or more limitation in ADLs have higher enrollment rates than those with no such limitations. Model 3 adds an indicator of access to care--measured by the length of time it takes to get to the doctor's office--to the basic regression model. The results show that those having greater distances to care have slightly higher enrollment rates, though the variable is not statistically significant.

4.4 Sources of Information and Barriers to Enrollment

Sources of Information

Table 4.8 shows results on beneficiaries' sources of information about Medicare in general and the QMB program in particular. The table indicates that only half of eligibles said that they received information about Medicare in the mail from the government. Enrollment rates were slightly higher for those who did not think they received such information. For those who said they did receive information, most affirmed that the words were easy to understand (73 percent) and that the words were printed large enough (88 percent).

In response to a question asking how they preferred to receive information about the Medicare program, the most popular response was by notice (43 percent), followed by pamphlet (32 percent), TV or radio (27 percent), letter (16 percent), newspaper (16 percent), the AARP (12 percent), and doctor (9 percent). Enrollment rates were highest for those who preferred to receive information from a social or welfare worker (enrollment rates of 76 percent), from a clergy member (59 percent), and from a family member or friend (59 percent).

Table 4.8: Sources of Information

	Percent of Eligibles	Tendency to Enroll	
		Enrolled	Non-Enrolled
Do You Receive Medicare Information in the Mail From the Government?			
Yes	50%	39%	61%
No	46%	42%	58%
Don't Know	4%	52%	48%
Were The Words Easy to Understand?			
Yes	73%	39%	61%
No	22%	39%	61%
Don't Know	3%	41%	59%
Were The Words Printed Large Enough?			
Yes	88%	40%	60%
No	9%	35%	66%
Don't Know	3%	53%	47%
How Do You Prefer To Receive Information About The Medicare Program?			
TV or Radio	27%	43%	57%
Newspaper	16%	37%	63%
Social/Welfare Worker	6%	76%	24%
Health Insurance Co	4%	16%	84%
Doctor	9%	54%	46%
Clergy	1%	59%	41%
Notice	43%	45%	55%
Letter	16%	40%	60%
Pamphlet	32%	38%	63%
Social Security Office	9%	43%	58%
AARP	12%	22%	78%

Table 4.8 Sources of Information (Cont'd)

	Percent of Eligibles	Tendency to Enroll	
		Enrolled	Non-Enrolled
Senior Citizen Center	6%	43%	57%
Family/Friend	1%	59%	41%
Other	4%	60%	40%
Have You Heard Of The QMB Program?			
Yes	7%	60%	40%
No	91%	40%	61%
Don't Know	2%	58%	42%
Are You A QMB?			
Yes	5%	94%	6%
No	6%	19%	81%
Don't Know	88%	40%	60%
Have You Applied For The QMB Program?			
Yes	1%	39%	61%
No	6%	18%	82%
Inapplicable	93%	43%	57%

Table 4.8 also shows that very few eligibles (7 percent) had ever heard of the QMB program. Enrollment rates were higher for those who had heard of the program (60 percent) compared to those who had not (40 percent). Only 5 percent of eligibles said that they were enrolled as QMBs. Of this group, 94 percent were, in fact, enrolled. Of the 6 percent who said that they were not enrolled, 19 percent actually were. Of the 88 percent who did not know whether they were QMBs, almost 40 percent were enrolled. Finally, only 12 percent of respondents said that they had applied for the QMB program (and 39 percent of these were enrolled).

Reasons for Nonparticipation

Table 4.9 shows the major reasons non-enrollees gave for not participating in the program. Most said that they did not need it (33 percent), or that they did not think they qualified (27 percent). Sixteen percent of respondents said that they did not know about it. Other frequently provided responses were that it was too much trouble (7 percent), they just didn't do it (3 percent), and that they didn't want welfare (3 percent).³

In Table 4.9a, we present these responses by income. As shown, the percentage of respondents saying that they didn't need the program did not vary much across income groups. Those saying they did not believe they qualified rose with income (from 26 percent for those with incomes under \$5,000 to 48 percent for those with incomes above \$15,000). The percentage who didn't know about the program fell with income, from 17 percent in the lowest income category to 10 percent in the highest category. Those with lowest incomes were most likely to say that it was too much trouble or that they could not get out to enroll.

Table 4.9b shows how responses vary by education level. The percentage of those responding that they did not qualify for the program rose with education -- from 27 percent for those with an eighth-grade education or less to 39 percent for those with at least some college education. The percentage saying that they did not know about the program fell with level of education, from 16 percent for those in the lowest category to 12 percent for those in the highest. Those with the least education were most likely to respond that it was too much trouble or that they could not get out to sign up.

³Note that our classifications were developed based on respondents' verbal responses to questions. In some cases, however, beneficiaries provided more than one reason for not participating (e.g., saying that they did not need the program and that they did not want welfare). We classified responses based on the first statement made.

Table 4.9: Reasons for Not Participating in the QMB Program

Reason	Percent
Don't Need It	33%
Don't Think I Qualified	27%
Didn't Know About It	16%
Too Much Trouble	7%
Just Didn't/No Reason	3%
Don't Want Welfare	3%
Don't Know How	1%
Couldn't Get Out To Do It	1%
Applied/Didn't Qualify	0%
Other	9%

Table 4.9a: Reasons for Non-Participation by Income
(% in Category)

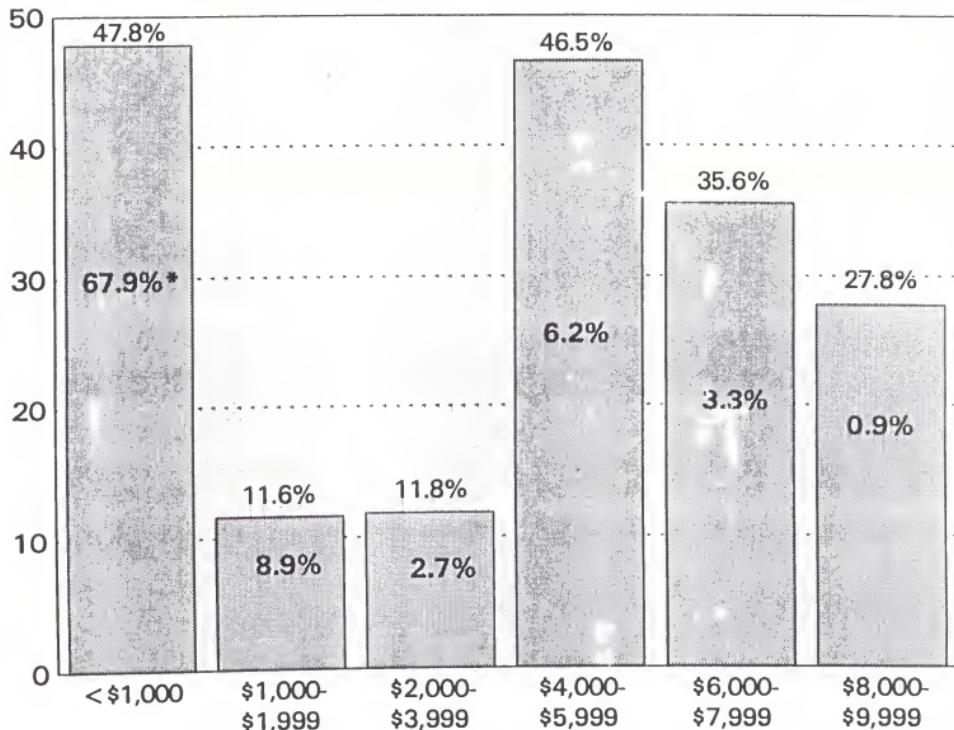
	< 5000	5K - 10K	10K - 15K	15K - 20K	20K+
Don't Need It	30	32	32	36	32
Do Not Qualify	26	28	36	34	48
Didn't Know About It	17	17	18	10	10
Too Much Trouble	12	4	2	5	0
Just Didn't	1	6	0	0	0
Don't Want Welfare	2	4	3	4	2
Do Not Know How	2	1	0	2	2
Could Not Get Out	3	1	0	0	0
Applied/Didn't Qualify	0	0	3	0	0
Other	8	8	7	9	0

Table 4.9b: Reasons For Non-Participation By Education Level
(% in Level)

	Years of Education		
	<8	9 - 12	College +
Don't Need It	29	36	31
Do Not Qualify	27	30	39
Didn't Know About It	16	14	12
Too Much Trouble	8	4	5
Just Didn't	2	3	4
Don't Want Welfare	3	4	3
Do Not Kn ^v How	1	2	0
Could Not Get Or .	1	1	0
Applied/Didn't Qualify	1	0	0
Other	12	7	5

Figure 4.1

Percent Enrolled in QMB by Income * *

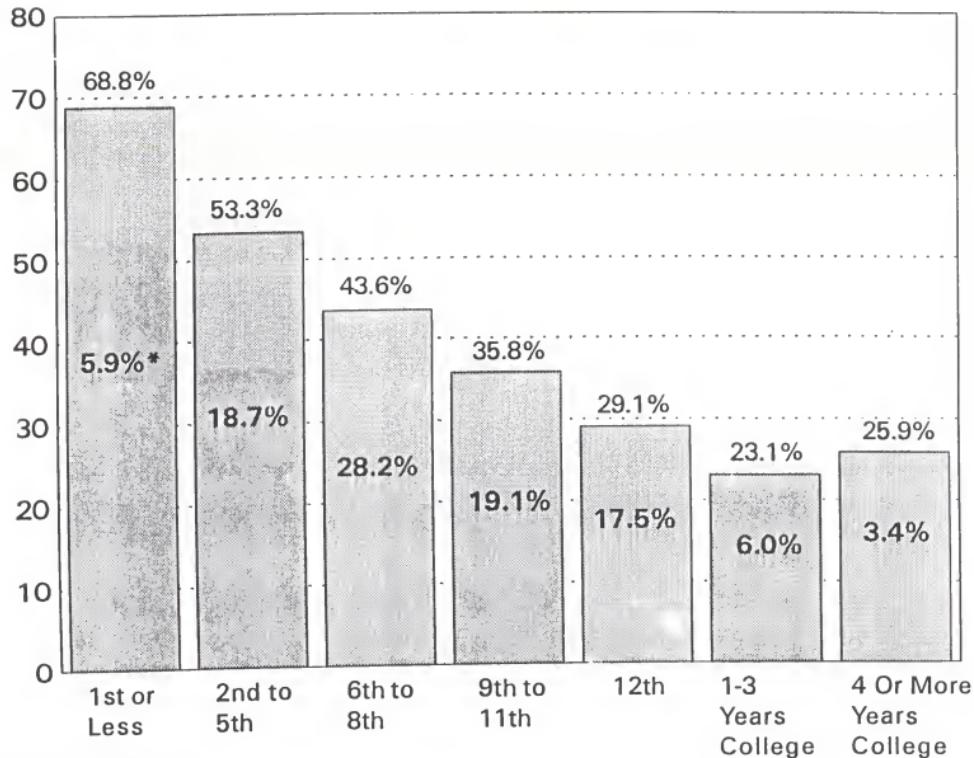


* = Percent of Eligibles

** = Income Determined on Round 6 of CBS

Figure 4.2

Percent Enrolled in QMB by Education



* = Percent of Eligibles

Figure 4.3

Percent Enrolled in QMB by Race

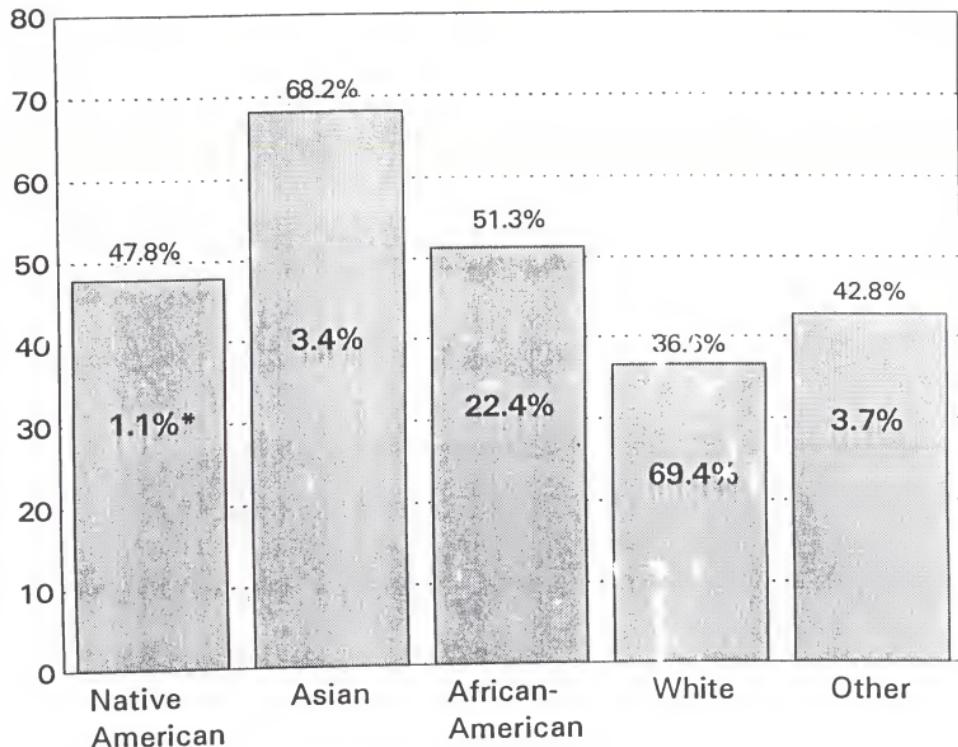


Figure 4.4

Percent Enrolled in QMB by General Health

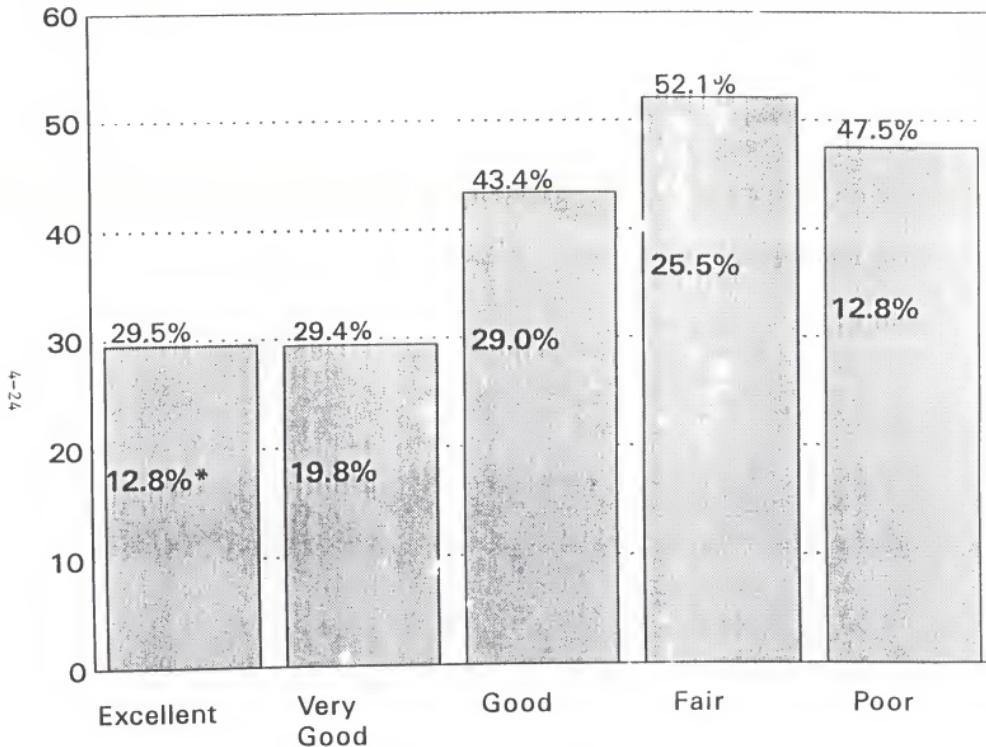
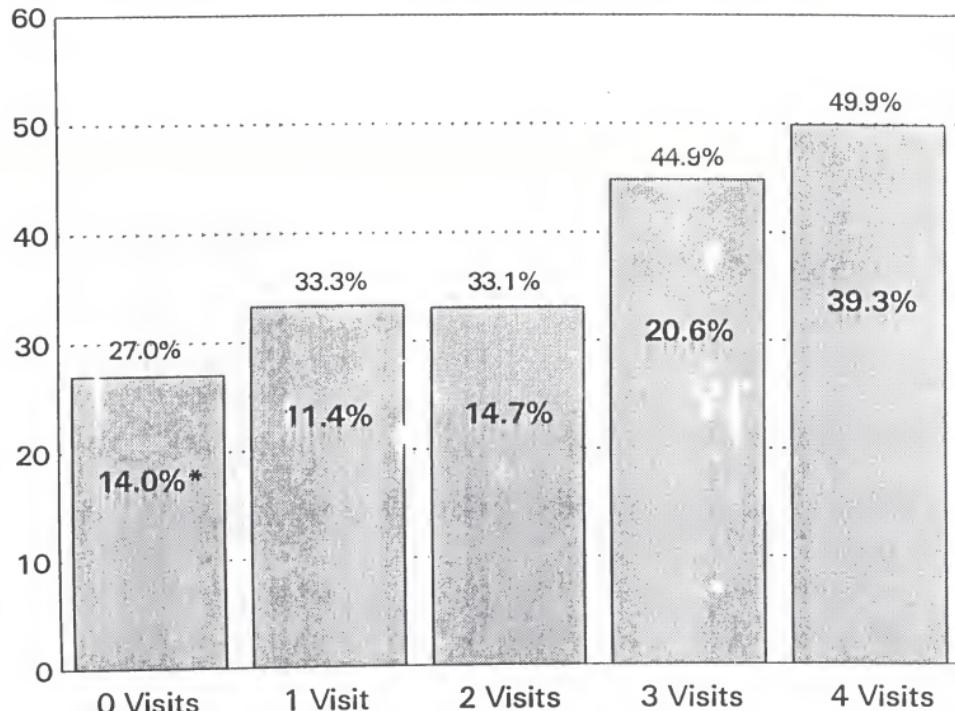


Figure 4.5

Health Care Utilization by Physician Visits* *



* = Percent of Eligibles

** = Includes Rounds 1 Through 4 of CBS. Maximum of One Visit per Round.

Figure 4.6

Health Insurance: Had Medicaid On 12/31/92

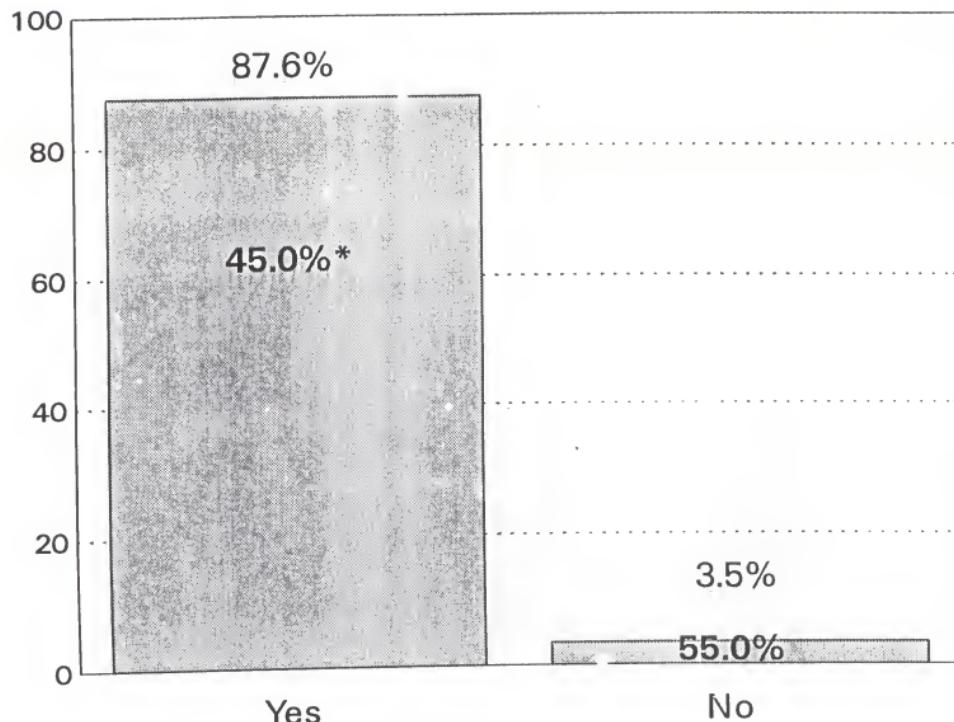
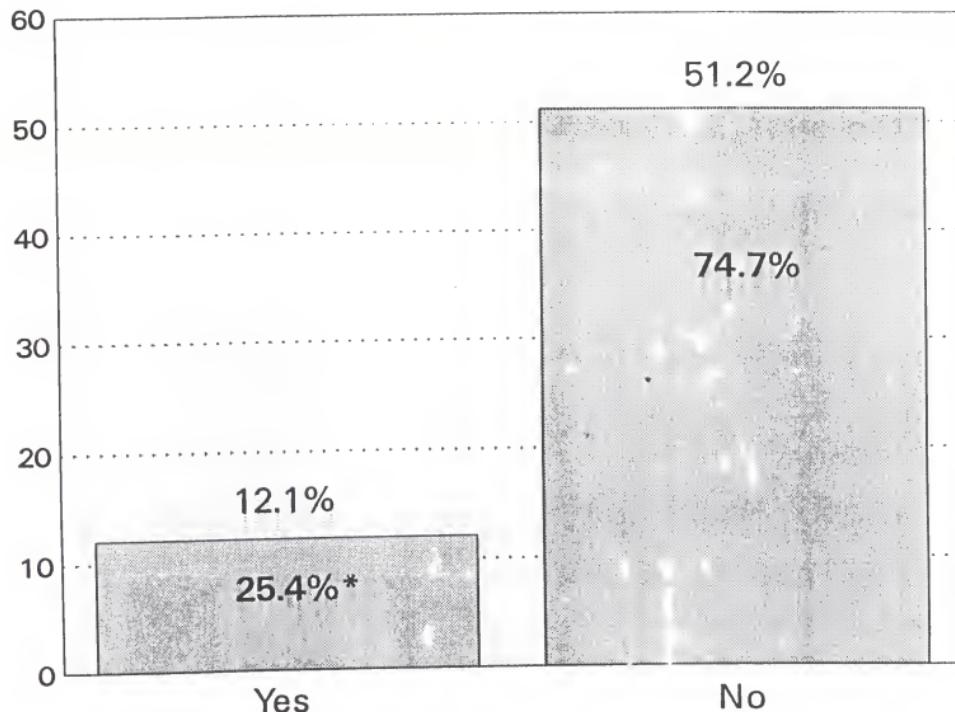


Figure 4.7

Health Insurance: Other Private Insurance



* = Percent of Eligibles

CHAPTER 5

DISCUSSION

5.1 Understanding OMB Enrollment Rates

Several important findings emerge from our analyses. First, many eligible beneficiaries are still not enrolling in the QMB program. According to our estimates, as of early 1993, only 41 percent of eligibles were participating.

A second important result is that those who are enrolling tend to be those most in need of the program. Eligibles with lower incomes and higher health care utilization are more likely to participate, for example. Among eligibles, these are the two subgroups most vulnerable to Medicare out-of-pocket costs -- lower income beneficiaries because they have less money with which to pay such expenses -- and heavy users because with each encounter with the health system, they are likely to incur additional out-of-pocket costs. Non-enrolled eligibles who are not heavy users of medical services have less of a burden from deductibles and copayments (though they are still assessed a monthly Part B premium (\$41.10 in 1994).¹

The data indicate that other vulnerable populations also have higher enrollment rates. For example, those more socially isolated (e.g., those reporting no contacts with friends or family members during the previous two weeks) have higher enrollment rates. Widowed, divorced, or never married individuals are more likely to enroll than married beneficiaries. Beneficiaries residing in rural areas and those living farther from their usual source of care have higher enrollment rates. Beneficiaries with little education are much more likely to be enrolled.

¹Beneficiaries may have other out-of-pocket expenses for items such as prescription drugs.

In addition, those participating in other government health and assistance programs are much more likely to be enrolled as QMBs. For example, enrollment is very high among dual eligibles -- those who qualify for Medicare and Medicaid. Over 87 percent of those indicating they received Medicaid were enrolled, as were over 95 percent of SSI recipients. Over 82 percent of those receiving other welfare income were enrolled, as opposed to 32 percent among those who were not receiving such income.

In general, our findings are consistent with other studies that have reported low participation in income-related government programs. As noted in chapter 2, studies have found that only 54 to 61 percent of the elderly population eligible for SSI enroll in the program (Lewin/ICF, 1989). It is interesting to speculate on why QMB enrollment rates appear to be even lower than SSI enrollment rates. One reason may be that the QMB program is newer, and therefore, fewer people know about it. Another may be that the income threshold for QMB eligibility is higher, and therefore, more individuals believe themselves to be ineligible or do not take the trouble to enroll. Also, because the QMB program is a supplement to an existing program and not a benefit unto itself, it may be a difficult one to understand.

Our findings are also consistent with other studies which reported that participation in one public program increases the likelihood of participation in another (see chapter 2). It appears that QMB eligibles who have some contact with the "system" -- through other government health or welfare programs -- have higher enrollment rates.

Although the program seems to be serving those most in need, some troubling realities remain. First, the program is not serving many individuals for whom it is intended. Enrollment rates remain low even among truly needy individuals. About 48 percent of those with incomes under \$5,000 annually are not enrolled in the program. Moreover, many eligible beneficiaries are incurring large out-of-pocket costs associated with hospital and physician visits. Less than half of those with at least one hospital visit (who thus incur the \$696 deductible per hospitalization) during the previous 18 months were enrolled. Moreover,

The results are also consistent with other research findings that informational barriers are an important reason for low enrollment. As noted in chapter 2, Louis Harris and Associates (1987) reported that among those who were eligible but not participating in the SSI program, 43 percent of eligibles believed themselves to be ineligible, and another 43 percent were unsure of their status. Coe (1983) found that informational barriers were a significant obstacle for potential Food Stamps recipients; more than 40 percent of those meeting the eligibility criteria did not think they were entitled to the benefit.

Our results indicate that lack of knowledge -- defined as those who said they did not believe they qualified (27 percent); those who did not know about the program (16 percent), and those who didn't know how to enroll (1 percent) about the QMB program -- was the most important barrier for about 45 percent of non-enrollees.

Moreover, our findings are consistent with others who have suggested that informational barriers were more of a problem for lower income individuals. Bendick (1980), for example, reported that those at the lower end of the income eligibility scale may have different reasons for not participating, most of which are out of the eligible person's control, including low education levels, poor mobility, program complexities, and lack of assistance. We found that among nonparticipants, those with lower incomes and less education were more likely to report that they didn't know about the program, that it was too much trouble, or that they could not get out to get it.

We note, though, that lack of mobility did not seem to be a major barrier to QMB enrollment. In fact, informational barriers were much more important than "physical" barriers. Only 7 percent of the nonenrollees reported that their primary reason for not enrolling was that it was too much trouble, for example, while only one percent said their primary reason was lack of mobility.

Moreover, compared to other studies, a higher percentage of respondents in our study (33 percent) reported that they did not need the program. There may be two reasons for this.

One is that our population includes individuals with higher incomes than those of people in previous studies of SSI and Food Stamps enrollment. A second reason may be our methodology for coding responses. We categorized responses according to the first verbal reply recorded from the survey. Some individuals who said that they did not need the QMB program went on to report other reasons -- for example, that they did not want welfare. Thus, this result may be in part an artifact of our methodology.

Finally, we note that our findings differ somewhat from the report by Families USA. In particular, we report fewer enrolled eligibles (41 percent) than was noted in the Families USA study (53 percent). Appendix A discusses in more detail the reliability of our estimate, and potential reasons for this discrepancy.

5.2 Does QMB Enrollment Lead to Higher Utilization of Services?

Increasing enrollment is likely to improve low-income Medicare beneficiaries' access to health care. A number of studies (McMillan et al., 1983; Berk and Wilensky, 1985; Dunlop et al., 1989) comparing health care utilization patterns of poor elderly persons receiving Medicare and Medicaid benefits with those covered by Medicare only have found higher utilization rates among the dually covered. Although these studies did not differentiate between the QMB-only and full Medicaid population, the findings suggest that enrollment in the Medicaid program, including the Medicare Buy-In, may help to improve access to care for the poor elderly.

CHAPTER 6

OUTREACH TO LOW-INCOME SENIORS: WHAT WORKS? KEY FINDINGS FROM FEDERAL AND STATE PROGRAMS

6.1 Introduction

In the past 20 years, many public and private organizations have conducted outreach activities to increase participation by the low-income elderly in publicly funded health and social service programs. To provide the Health Care Financing Administration (HCFA) with information on the nature and impact of past outreach projects and to identify strategies which could be effective for QMB outreach, we conducted a comprehensive review of the literature and contacted officials involved with a wide variety of outreach programs at the federal, state, and local levels. We define outreach as it has been described in the social service literature, as an effort "to locate and link the population in need with the services available" (Stuen, 1985). Outreach generally involves one or more of the following activities: 1) disseminating information to increase awareness of available benefits; 2) identifying people who may be eligible for these programs; and 3) providing assistance in the application process (AARP, 1991a; Families USA, 1993).

In Section 6.2 of this chapter, we describe outreach efforts aimed at increasing participation in local social service programs. Section 6.3 summarizes efforts to boost enrollment in Medicaid/QMB, as well as the Supplemental Security Income (SSI) and Food Stamps programs, which have likewise had low proportions of eligible populations enrolled (Lewin/ICF, 1989; Coe, 1983; ICF, Inc., 1987,1988). In Section 6.4, we discuss the correlation between the aggressiveness of state outreach efforts and their QMB enrollment rates, and we describe the results of a regression analysis to test the effect of state outreach programs on QMB participation. In Section 6.5, we summarize the lessons learned from past outreach efforts, and finally, in Section 6.6, we review the comments of outreach

professionals who met to discuss findings of this study¹ and make recommendations for future QMB outreach (See Appendix B for a full list of the technical advisory panel members).

6.2 Local Social Service Outreach

Findings from local social service outreach initiatives suggest that program enrollment can be maximized through several strategies: using two-way, interpersonal communication; involving community members in planning and implementation; utilizing outreach workers of the same racial/ethnic group as the target population; providing services in convenient locations; and presenting campaign materials in a format familiar to community members. Kushler and Davidson's (1978) study comparing strategies to increase low-income seniors' use of a local information and referral (I&R) service found that elderly individuals contacted through one-on-one home visits by outreach workers were most likely to state an intent to use services and to actually sign up with the program. Among the 210 elderly Michigan residents targeted, home visits were most likely to result in either subsequent utilization of services, a request to be placed on the I&R newsletter mailing list, or indication of commitment to participate in the I&R program. Seventy-nine percent of the elderly who received a home visit gave verbal indication that they would participate in the I&R program in some way; 23 percent of those visited ultimately used I&R services. Telephone contact was second in overall effectiveness (with 28 percent of those contacted indicating that they would participate and 19 percent ultimately receiving services), followed by "personalized" mail (with 10.5 indicating intent and receiving services), which consistently used words such as "you," "we," and "your neighbors" and included an endorsement from local residents who had used I&R services to encourage recipients to contact "the helpful people at the I&R center" (Kushler and Davidson, 1978). Informational mail with no personal element was the least effective (with verbal commitment among two percent and participation among four percent of those targeted).

¹ These individuals attended the final technical advisory panel meeting for the QMB project, held at our Bethesda office on Thursday, July 7, 1994.

Analysis of an early 1980s project encouraging Mexican-Americans to use psychological counseling services found that several strategies worked particularly well. These included building relationships with community leaders; forming a community advisory committee; locating services within the minority neighborhood; using outreach workers who had the same ethnic background and spoke the same language as individuals in the target population; and presenting outreach messages in a format familiar to the group, in the script of a play performed in Spanish. After three months of the project, the outreach counselor had met the goal of conducting 12.5 interviews per week with clients from the target population. During the first eighteen months of the project, the project achieved the goal of bringing the representation of Mexican-Americans in the agency's caseload up to their proportion of the general population in the outreach site (Tarrant County, Texas). Near the end of the project's second year, a second counselor was added to meet increasing demand. As a result of the project team's efforts, Mexican American community leaders' initial resistance and hostility to the concept of counseling decreased dramatically (Watkins and Gonzales, 1982). In a survey of 22 former clients, 73 percent indicated that "things had improved" since their first session. Eighty-two percent said they would consider going back to the agency if they needed help in the future, and all said they would refer a friend to the agency (Watkins and Gonzales, 1982).

In an overview of issues involved in developing community-based outreach programs for the elderly, Stuen (1985) highlighted several strategies which have been successful. Findings from a Massachusetts senior citizen outreach project suggest that using elderly outreach workers can be quite effective. Based on results of this project, Stuen recommended conducting studies to analyze the target population's needs and attitudes toward a variety of services before outreach activities begin. Elderly residents of the community should be asked to participate in both the community needs assessment and in the planning process (Stuen, 1985). In designing outreach materials, she noted, project staff should be sensitive to the characteristics of the target population, for example, developing human interest stories for the lay audience, while providing more technical information for health and social service professionals. Citing an approach used by the Community Service Society of New York's

Natural Supports Program, she emphasized the importance of communicating with "significant others" -- family and friends who may encourage or help the elderly apply for benefits.

Finally, Stuen indicated that to cause significant change, outreach campaigns must go beyond publicity and provide easily accessible locations for program enrollment.

6.3 Outreach for Federal Programs

A number of federal and state agencies, national advocacy groups, and nonprofit organizations have worked to increase enrollment in the Medicaid, QMB, Supplemental Security Income (SSI), and Food Stamps programs. Based on our review of journal articles, agency reports, publications of the American Association of Retired Persons (AARP), and conversations with agency and program officials we have identified a broad spectrum of outreach strategies. These include broadcasting radio and television public service announcements (PSAs), establishing hotlines, using utility workers to identify potential eligibles, and recruiting volunteers to help people apply and enroll.

QMB/Medicaid

Table 6.1 lists a number of QMB/Medicaid outreach programs (see table at end of chapter). We provide a more detailed description of these projects below.

■ HCFA Outreach Programs

In August 1991, HCFA formed an Outreach Workgroup along with other HHS agencies and public interest groups, to examine strategies for increasing public awareness of the QMB program (HCFA, 1992). Based on the workgroup's recommendations, the agency has done the following:

- published news and feature articles on the QMB program in AARP's member magazine, and in daily and weekly newspapers;
- distributed 1 million copies of a QMB leaflet and 2 million publications with QMB information to over 7,000 supermarkets throughout the country;
- mailed public service announcement videotapes to 325 television stations and 4,000 radio stations nationwide;
- developed a QMB fact sheet for distribution to senior centers;
- included QMB information in the Medicare Handbook mailed to all new Medicare beneficiaries; and
- advised Medicare beneficiaries (through the Medicare Handbook) that they could call the toll-free Medicare hotline for information on the QMB program. From March 14, 1992, when QMB information was added to the hotline, through December 1993, the hotline received over 30,000 calls about the program.

Currently HCFA is administering the Information, Counseling, and Assistance (ICA) grant program authorized by the Omnibus Budget Reconciliation Act of 1990. The ICA program funds outreach services for QMB, as well as for other Medicare and Medicaid benefits, Medicare supplemental policies, and long-term care insurance. A three-year, \$9.92 million annual appropriation divided among all 50 states has been used for activities such as:

- training volunteers (recruited by nonprofits, legal services, and senior citizen organizations) to screen potential eligibles, to make presentations about QMB in convenient neighborhood locations and at meetings of community organizations, and to help the low-income elderly fill out applications;
- developing brochures, posters, and flyers with information about QMB; and
- creating "how to" kits for volunteers on working with the media.

Health Economics Research, Inc. is in the process of evaluating the effectiveness of program activities undertaken from April 1, 1993 to March 31, 1994 (Lang, 1993). Continuation of the ICA program is subject to Congressional approval.

In addition to monitoring the ICA program, HCFA recently developed a QMB outreach "kit," which includes an informational video and a shortened benefits screening form to identify individuals potentially eligible for the program. In January and early February 1994, the kit was distributed to community health centers; Area Agencies on Aging (AAAs); social workers; national beneficiary organizations; retired senior volunteer groups; and minority senior citizens' associations across the country. This method of distribution is intended to promote communication about the program at the grass roots level. Senior citizens determined to be potentially eligible for QMB will be referred to their local Medicaid office for final eligibility determination (Shipley, 1994).

HCFA has also used special mailings to encourage low-income seniors to enroll. In February 1993, HCFA's Medicaid Bureau mailed Medicare Part A application forms to 250,000 SSI recipients who were not receiving QMB benefits. Enrollment in SSI indicates eligibility for QMB, as the SSI income and asset limits are lower than those for QMB. The mailings were sent to people in the 17 states which require individuals to take the initiative to enroll in Medicare Part A rather than automatically signing them up for the program. As Part A participation is a requirement for QMB enrollment, a substantial increase in Part A enrollment in these states could have a significant impact on QMB program participation. The response rate to the mailing, which simply asked people to sign and mail back a pre-addressed form, was 30 percent. Since February 1993, approximately 66,000 additional people have enrolled in the QMB program as a result of this mailing (Spàracino, 1993).

■ State Outreach Programs

AARP publications have grouped state outreach efforts into three basic categories: 1) those which simply provide information; 2) those which seek to identify individuals

Seventeen states were doing mailings; six states were broadcasting PSAs; 12 states were "outstationing" eligibility workers in neighborhood locations; 26 states were working with community groups; 18 states were issuing press releases; 34 states had distributed brochures; 40 states were working with Area Agencies on Aging, and nine states were conducting "other" types of outreach (APWA, 1993). See Table 6.4 for APWA's listing of outreach activities by state.

■ Outreach by Advocacy Groups

The National Council of Senior Citizens has printed articles on QMB in its newspaper, Senior Citizen News, which is distributed to members throughout the country. The organization's state and local affiliates have also publicized the QMB program through newsletter articles, special mailings, and discussions at club meetings.

Under a grant from the Administration on Aging, the National Indian Council on Aging (NICOA) is working to enroll Native Americans in a number of public benefits programs, including QMB. NICOA trains Native American service providers to identify elderly individuals in their own tribes and reservations who may be eligible for benefits. The service providers translate benefits information, help with agency interviews, and arrange for transportation to government offices. In addition, tribe members who coordinate delivery of federal nutrition assistance to low-income Native American elderly conduct screening for QMB, as well as for SSI, Medicaid, and energy assistance (Families USA, 1993).

United Seniors Health Cooperative has developed Benefits Outreach and Screening Software (BOSS), which prescreens individuals to determine potential eligibility for the major federal benefit programs, including Medicaid, QMB, Supplemental Security Income (SSI), the Low-Income Home Energy Assistance Program (LIHEAP), and Food Stamps, as well as state and local social service programs. Since 1987, BOSS software has been installed at 250 agencies and organizations with low-income clients (such as hospitals, social service agencies,

Table 6.4: State Outreach Strategies

State	Mailings	PSA	Outstation	City Groups	Press	Brochures	Aging Networks	Other	Total Strategies
Alabama	QMB			both	both	both	both		5
Alaska							both		1
Arizona				both		both			3
Arkansas	QMB	QMB	QMB				QMB		4
California	QMB	QMB			QMB	QMB			4
Colorado				both		both	both		3
Connecticut						QMB	QMB		2
Delaware	QMB			QMB	QMB	both	QMB		5
Dist of Columbia*									
Florida			QMB	QMB	QMB	QMB	QMB		5
Georgia	QMB		QMB	QMB		QMB	QMB		5
Hawaii			both	both	QMB	both	both		5
Idaho						both			1
Illinois				both	both		both		3
Indiana					QMB				1
Iowa						QMB	QMB		2
Kansas				QMB		QMB	both		3
Kentucky						QMB	both		2
Louisiana			both	both			both		3
Maine*									
Maryland	QMB			QMB			QMB		3
Massachusetts	both			both		both	both		5
Michigan					QMB	both	QMB		3
Minnesota						QMB	QMB		2
Mississippi				both	both	QMB	both		4
Missouri	QMB								1
Montana				both		QMB	both		3
Nebraska						both	both		2
Nevada	QMB			QMB		QMB	QMB		4
New Hampshire	QMB			QMB	QMB	QMB	QMB		5
New Jersey			QMB			both	both		3
New Mexico				both	QMB	both	both		4
New York	QMB						QMB		2
North Carolina			both	both	both	QMB	both		5
North Dakota				both		both	both		3
Ohio						QMB	QMB		2
Oklahoma							QMB		1
Oregon	none								0
Pennsylvania	QMB	QMB			QMB	QMB	both		5
Rhode Island*									5
South Carolina	none								0
South Dakota	both	QMB	both			both	both		5
Tennessee	QMB	QMB	QMB	QMB	QMB	QMB	QMB		7
Texas					both		both		2
Utah	QMB				QMB	QMB	QMB		5
Vermont	none								0
Virginia						QMB	QMB		2
Washington						both	both		2
West Virginia			QMB			QMB	QMB		3
Wisconsin			both	both	both		both		4
Wyoming					QMB	both	QMB	QMB	4

* Did not respond to survey.

Both = targeted to both QMB and SLMB eligibles.

Source: American Public Welfare Association, Qualified Medicare and Medicaid Beneficiaries:

Report of a Survey, Washington, DC, September 1993.

Area Agencies on Aging, senior citizen meal sites) in 22 states (Mondin, 1993). Agency staff or volunteers refer individuals determined to be potentially eligible to the appropriate benefits offices. Originally, the program was used as an outreach tool solely for the elderly; however, it has recently been modified for use with all age groups. BOSS has shown great potential to identify individuals who may be eligible for benefits; recently, during a 17-month outreach project which included BOSS screening, Bread for the City, a Washington, D.C. social service organization, determined eligibility for a total of \$1 million in SSI, Medicaid, and Food Stamps benefits (Mondin, 1993). However, BOSS's limited ability to actually increase enrollment was illustrated during a two-year pilot demonstration project in Ohio's Cuyahoga, Geauga, and Lake Counties. In evaluating results of this project, a local nonprofit organization found that only 22 percent of 170 senior citizens screened through BOSS subsequently applied for benefits (Federation for Community Planning, 1990). Thirty-six percent of those who learned about new benefits programs through BOSS (n=120) indicated that they would have applied if assistance, such as transportation or help with gathering documents, had been provided (Federation for Community Planning, 1990). Thus, in some cases, providing help with the application process can be critical in determining whether individuals will enroll.

United Seniors is currently planning a three-year demonstration project, to be implemented in two Maryland counties, (Baltimore and Prince George's), in March 1994, which will allow government agencies to track individuals who may be eligible for benefits. Under this program, public agencies and private nonprofit organizations using BOSS in community outreach sites will be able to print not only screening forms, but also actual applications for 50-100 federal and state benefits programs, including QMB. Once individuals complete these forms at the project sites, application data will be transmitted to the appropriate government agency via modem, eliminating the need for applicants to make a separate trip to government offices. If individuals are determined to be eligible, agency staff will contact them directly. Ultimately United Seniors hopes to implement the program throughout the State of Maryland.

Supplemental Security Income (SSI)

The following section provides an overview of SSI outreach activities conducted by public and private organizations. These programs are summarized in Table 6.2 at the end of the chapter.

■ SSI Outreach by the Social Security Administration (SSA)

In 1984, as mandated by Public Law 98-21, the Social Security Administration initiated two outreach efforts aimed at individuals likely to be eligible for SSI (which provides monthly cash benefits to low-income individuals who are either over 65, blind, or disabled). The first was a one-time mailing in 1984, sent to 7.6 million Social Security beneficiaries age 65 and over whose benefits were low enough to indicate potential eligibility (SSA, 1988). According to a follow-up survey administered after the mailing, 79,000 elderly, or approximately one percent of those notified, subsequently applied for SSI based on receipt of the notice. Of those who applied, 58,000 (0.7 percent of the total receiving the mailing) received benefits. In July 1983, SSA also initiated an ongoing program, which involves mailing SSI informational notices to approximately 110,000 Social Security beneficiaries each month along with their notification of eligibility for Medicare. According to an SSA analysis (1988), the ongoing mailing resulted in the award of 2,000 additional SSI benefit checks each month between 1983 and 1988.

In FY 1990, SSA provided a total of \$3 million to 25 social service providers, advocacy groups, and state government organizations to identify individuals potentially eligible for SSI and to help them through the application process. In each subsequent year through FY93, grants ranging from \$6 million to \$8 million have been awarded to conduct outreach in additional sites (AARP, 1991b; Crawford, 1993). Currently, the program is being implemented in 49 communities across the country. While results of the ongoing evaluation are not expected until late 1994 or in 1995, anecdotal reports have identified several factors critical to program success. First, outreach should be targeted to specific low-

income subpopulations, by racial/ethnic group or by disability status. In its preliminary review of the FY90 outreach projects, which were not targeted to subgroups within the SSI population, SSA staff noted substantial gaps in program impact. Therefore, in the FY91 grant cycle, the agency placed priority on funding projects aimed specifically at Native Americans, African Americans, and the mentally ill (Crawford, 1993). Other projects have sought to enroll elderly Asian-Americans, Hispanics, the homeless, persons with AIDS, young adults with developmental disabilities, and disabled children. Outreach staff indicate that to substantially increase program participation rates, it is not enough simply to identify individuals who may be eligible for benefits; rather, outreach programs must actively help people enroll (Crawford, 1993).

SSA is currently conducting a pilot project with the Department of Veterans Affairs (DVA) in Dallas, New York City, and Los Angeles that takes precisely this approach. The program, which targets the chronically mentally ill homeless population, sends outreach workers into the streets to encourage people to apply and to provide enrollment assistance. Once individuals indicate a willingness to participate, the project team helps them apply for a variety of programs, including SSI, VA medical care, vocational rehabilitation, and substance abuse counseling. DVA plans to conduct an evaluation of the project to determine its effect on enrollees' quality of life, as well as the actual impact on program participation rates (Crawford, 1993).

- State SSI Outreach Efforts

Providing Information: In addition to providing information through its hotline about SSI, Florida requires each region to file an annual outreach plan, which generally includes dissemination of information through the media and agency newsletters, as well as distribution of flyers to service providers. Maryland's SeniorReach program works with private corporations to provide information about benefit programs in utility bill inserts and company newsletters (AARP, 1991b).

Combined Approaches: Through Maryland's Gatekeeper Program, utility workers check on senior citizens during regular meter reading visits and refer those in need of assistance to the state's Senior Information and Assistance Program (SIAP). SIAP provides case management and follow-up to ensure that potentially eligible seniors apply for and receive the benefits to which they are entitled (AARP, 1991b).

Since 1991, New York has provided a total of \$2 million to community organizations and Area Agencies on Aging to conduct SSI outreach (Mooney, 1993). Approximately 10 grants have been awarded each year, for projects targeting particular racial/ethnic groups (e.g., the Brooklyn Chinese-American Association and the Institute for Puerto Rican/Hispanic elderly), as well as individual SSI subpopulations (local offices for the aging and VISIONS/Services for the Blind and Visually Impaired). One project targeting low-income Chinese-Americans offers a low-cost luncheon (ranging from 25 cents to two dollars) during which outreach workers conduct an informational workshop on SSI. Five of these lunches have been held each year since 1991, attracting between 400 and 600 persons each time (Mak, 1993). The association's other activities include issuing press releases on SSI to the major Asian-American newspapers in New York City; conducting door-to-door outreach; prescreening individuals for benefits; and coordinating with SSA staff to conduct eligibility interviews in the association's offices. According to a progress report issued to the New York State Office for the Aging, approximately 16,000 individuals were reached or applied for benefits due to these efforts in fiscal year 1991-92, and 163 were ultimately deemed eligible for and enrolled in SSI.

The low proportion of New York residents reached who actually enrolled (approximately one percent in this case) is typical of most of the SSI outreach projects funded during the 1991-92 grant cycle. Overall, only about four percent of the 55,234 who were reached ultimately became SSI beneficiaries (Mooney, 1993). The State Office for the Aging cites several factors accounting for the low proportion of those reached who actually enroll, including: language barriers; mistrust of government; fear of deportation; the prohibition on foreign public assistance recipients sponsoring family members to come to the United States;

difficulty gathering required documentation; "burnout" among SSA workers who do not notice applications with incomplete information; long waits at SSA offices; a shortage of volunteers for outreach activities; transportation problems; and fear of crime in low-income neighborhoods, which inhibits door-to-door outreach efforts. The office notes, though, that the 1991-92 figures represent a substantial improvement over prior years.

SSI outreach strategies that have been most effective in New York State include: door-to-door solicitation; grass-roots organizing through churches; and providing outreach services where senior citizens congregate, such as in grocery stores and community centers (Mooney, 1993).

- **SSI Outreach by Advocacy Groups**

From September 1987 to March 1989, Families USA coordinated a program, known as Project SIGN-UP, to increase SSI enrollment among low-income elderly and disabled residents of the Boston metropolitan area (Jerry and Villers, 1992; AARP, 1991b). The project primarily targeted the Chinese and Hispanic communities; however, it was expanded to include Russian, Haitian, African-American, and white low-income seniors. The project's bilingual and bi-cultural outreach workers disseminated SSI informational flyers and brochures and made presentations on SSI at churches, ethnic fairs, family celebrations (in the Chinese community), shops, and restaurants. They also conducted SSI screening; provided application assistance; and served as translators for applicants who did not speak English. In Chinese neighborhoods, the outreach worker provided comprehensive case management services to all individuals screened and subsequently referred to the Social Security Administration. In addition, the project initiated a media "blitz" to increase awareness of SSI. Media activities included a live call-in television show about SSI, aired on local cable stations; a press conference featuring the mayor of Boston and over 100 low-income seniors; placement of articles in daily and weekly newspapers, the non-English press, and newsletters of aging, social service, and home care organizations; distribution of SSI informational leaflets in bags at grocery stores in low-income neighborhoods; and placement of posters on subway cars and

buses serving low-income neighborhoods (Jerry and Villers, 1992). The project also provided SSI outreach training to social service staff at 18 community-based agencies.

Overall, of the 735 individuals screened during Project SIGN-UP, 46.5 percent were found to be potentially eligible for SSI, and 28 percent ultimately enrolled. Fifty-six percent of those who contacted Project SIGN-UP said they called based on information or encouragement from another person, while only 11 percent contacted the project based on information heard from radio or television. Among those actually approved, 78 percent said they had heard about SSI through a "trusted individual" (which, in some cases, was an outreach specialist), compared to 9.7 percent for television, radio, and newspapers combined (Jerry and Villers, 1992). Just 4¹ percent said they had heard about SSI through a government agency. While the project received three times the number of inquiries during the media blitz period than it had during other times, many of those inquiries were by individuals with incomes and assets above the SSI eligibility limits; data analyses found that a higher percentage of the media blitz contacts were ineligible than were contacts generated from personalized outreach activities. Project staff did not publish rates of eligibility by specific communication channel. Furthermore, the study did not determine how many of the "trusted individuals" providing information to potential enrollees had actually heard about Project SIGN-UP through the mass media.

Training of community-based social service staff as part of Project SIGN-UP was found to substantially increase the level of SSI application assistance provided. A survey conducted several months after training found that 57.9 percent of community social service personnel were screening clients for SSI eligibility, compared to just 35.1 percent prior to training. Furthermore, the proportion of social service workers providing SSI application assistance increased from 43.9 percent to 59.6 percent, and the proportion accompanying clients to SSA offices rose from 35.1 percent to 43.9 percent (Jerry and Villers, 1992).

Outreach for the Food Stamps Program

The following is an overview of Food Stamps outreach projects undertaken by government agencies and private organizations. The components of individual projects and their results, when available, are summarized in Table 6.3 at the end of the chapter.

■ Federal Food Stamps Outreach

In 1972, the federal government initiated Project FIND, a nationwide effort to notify millions of low-income elderly of their potential eligibility for Food Stamps and other food assistance programs (AARP, 1991c). Coordinated by White House staff and several federal agencies, the project involved mass mailings with postcards that could be returned for more information. Local Red Cross volunteers were supposed to contact people who returned the postcards and help them apply for benefits. However, a 1974 General Accounting Office evaluation of Project FIND indicated that Red Cross volunteers often failed to follow up on information requests, particularly those made by inner-city residents. Frequently, there was no systematic coordination between volunteers and the Food Stamps offices. In some cases, these problems were attributed to the fact that volunteers did not receive adequate training and were not given enough time to handle the return postcards. Furthermore, in many cases, the brochures mailed to the elderly contained erroneous information about state eligibility limits (AARP, 1991c).

■ State and Local Food Stamps Outreach Efforts

Several state and local Food Stamps programs have taken a multi-faceted approach to outreach. A Duluth, Minnesota project established in 1986 targeted grocery store staff as well as potential beneficiaries (AARP, 1991c). In an effort to create a positive image of the program and improve treatment of Food Stamps beneficiaries by grocery store workers, project staff met with local grocery store owners to discuss the economic value of Food Stamps. In addition, volunteers who were already Food Stamps recipients identified family,

friends, and neighbors who were likely to be eligible for the program, helped them fill out the application form, and assisted them through the application process. Volunteers provided these services in their own homes or in convenient neighborhood locations. The program kept volunteers apprised of outreach activities through a project newsletter and maintained a sense of group solidarity through periodic meetings, sometimes with presentations by guest speakers. The Duluth program has not been evaluated; however, the number of households receiving Food Stamps stayed constant during the project period despite the fact that unemployment dropped substantially, suggesting that the program may have had an impact (AARP, 1991c).

From 1987-1989, Missouri's State Welfare Department* and a state hunger advocacy organization conducted a multi-part outreach program notable for its use of preliminary research (AARP, 1991c). Prior to developing the campaign message, the outreach coalition conducted a survey of Food Stamps recipients, advocates, and caseworkers to examine reasons for nonparticipation. Based on these findings, the project team developed material for newspaper articles, radio and television PSAs, as well as a video distributed to churches, community groups, and talk shows. The video sought to dispel myths about Food Stamps and address concerns of the elderly, farm families, and the homeless. In addition, the project distributed several sets of informational leaflets, each targeting specific groups, including the elderly. For the interpersonal component of the project, approximately 700 volunteers were trained to conduct prescreening and encourage those potentially eligible to apply. The project also sought to heighten agency staff's sensitivity to beneficiaries' problems; in support of this goal, the Department of Social Services held meetings with welfare caseworkers to make them more aware of the issues facing clients and to counter negative attitudes about the program. This combined approach was identified as the major reason for a substantial increase in Food Stamps enrollment during the two-year project period, in which the number of households receiving benefits increased from 138,000 to 154,000 (AARP, 1991c).

- Food Stamps Outreach Efforts by Private Organizations

In the mid-1980s, the Advertising Council conducted a national campaign to increase enrollment in the Food Stamps program. The campaign involved use of radio and television PSAs which provided information about Food Stamps, attempted to create a positive image of the program, and advertised a toll-free number for more information (AARP, 1991c). Individuals who called the number would receive an informational brochure, along with the name and address of their local Food Stamps office. An evaluative survey of the program found that of the 300,000 people who called the hotline, nine percent subsequently enrolled in the Food Stamps program (AARP, 1991c). It cannot be assumed, however, that enrollment resulted directly from contact with the hotline. Researchers have noted that the thousands of Food Stamps brochures distributed to local agencies and charitable organizations may have contributed to the increase in participation, and that many of the nine percent who enrolled might have done so even if they had not heard the PSAs or called the hotline. Furthermore, AARP has pinpointed several of the program's shortcomings. As the hotline was staffed by a commercial contractor with no specialized knowledge of the Food Stamps program, hotline workers did not provide eligibility information over the phone and could not assist callers in the application process. In addition, because the campaign was a one-time effort, its impact was necessarily limited.

A quite different strategy is being used by Project Bread, a nonprofit organization in Boston, Massachusetts (AARP, 1991c). Project Bread has established an ongoing Hunger Hotline which prescreens callers to determine their potential eligibility for Food Stamps and tracks them through the entire application process. The hotline, which is publicized extensively through the media and community organizations, uses workers who are knowledgeable about Food Stamps and can answer questions. Furthermore, hotline workers urge callers to apply for benefits if they are determined to be potentially eligible, and encourage them to call again if they encounter problems. Project Bread subsequently follows up with callers to determine whether they have applied, provides application assistance when necessary, and, in some cases, serves as an advocate for individuals whose applications are

denied. Project Bread staff also works with state and local organizations to remove barriers to participation in the Food Stamps program. Program evaluations conducted in 1986 and 1987 found that approximately 20 percent of Hunger Hotline callers subsequently received benefits (AARP, 1991c).

AARP's Comprehensive Outreach Demonstration and Ongoing Efforts

From 1989-1991, AARP coordinated a comprehensive outreach demonstration project to increase the number of low-income elderly receiving government benefits and to publicize the interrelationship of several benefit programs. The effort, funded by the Commonwealth Fund Commission on Elderly People Living Alone and implemented in 20 sites across the country, sought to increase participation in the Food Stamps, Medicaid, SSI, and LIHEAP programs (Silverstein and Puma, 1992). Some of the sites conducted outreach for just one of these programs; others targeted several at one time.

In each site, the cosponsoring agency (generally the local Area Agency on Aging) donated staff to the effort or delegated work to subcontracting agencies. The agency had two to three months to design a campaign and to form a community outreach coalition with other local organizations serving the elderly. Local coalitions convened a technical advisory panel which provided advice on campaign materials and strategy. Volunteers were trained to staff outreach activities, and a kickoff event was planned at each site to attract media attention and motivate volunteers. Many of the sites had previously been targeted for SSI outreach and, in fact, used some of the same methods, which included: appearances on radio and television call-in shows; radio and TV telethons which prescreened elderly callers to determine potential eligibility; interviews on television shows popular among the elderly; promotional articles in church bulletins and senior center newsletters; PSAs on local radio and TV stations; presentations at community organizations and health fairs; distribution of posters and brochures in churches, supermarkets, low-income housing units, doctors' offices, and other community locations; mailings to community leaders, churches, and senior citizens; and door-to-door canvassing in some sites (typically in low-income housing projects).

To help eligible elderly citizens apply for benefits, all demonstration sites operated hotlines to answer questions, prescreen for eligibility, and refer callers to the appropriate government agencies. Several sites established outreach stations in convenient neighborhood locations (i.e., libraries, mobile trailer parks) to distribute information, process outreach referrals, and provide assistance with applications. In addition, some of the sites designated a day for one-stop-shopping, so that senior citizens could have walk-in eligibility interviews at neighborhood senior centers and enroll in several programs at one time. In addition to streamlining the application process, this strategy removed the stigma associated with visiting a welfare office (Silverstein and Puma, 1992). At several sites, applicants were matched with an outreach worker who helped them gather the necessary documentation, arranged for transportation, and followed up after the eligibility interview providing additional help if necessary. To identify more people who might be eligible, coalition agencies reviewed their files for low-income seniors receiving one type of government assistance who might be eligible for others.

Despite the broad scope of these efforts, an evaluation of 16 of the outreach sites did not find any evidence that the project significantly increased participation in any of the programs targeted (Silverstein and Puma, 1992). However, data limitations may have obscured the campaign's true impact. The evaluation team found it difficult to obtain data specifically on the elderly who applied for and received benefits; often the data available (particularly Medicaid data) included nonelderly applicants and beneficiaries. Furthermore, the study was unable to control for other factors which could have affected enrollment rates, such as changes in state or federal Medicaid policy, changes in benefits application forms, or expansions in the hours of operation of government agency offices (Silverstein and Puma, 1992). In most sites, the program did, however, succeed in creating or improving positive working relationships among local agencies serving senior citizens, thereby enhancing the community infrastructure supporting the low-income elderly. This change could, in the long run, contribute to higher rates of participation in federal benefits programs. There were also anecdotal reports that the outreach programs which used outstationing or special events (i.e., application fairs to promote all of the major entitlement programs) attracted a substantial

number of elderly who needed some form of assistance (Silverstein and Puma, 1992). According to the evaluation team, these programs were most successful when they were promoted in advance by individuals or groups that the seniors knew and trusted.

Several factors may have hindered AARP's outreach efforts. First, many of the participating sites had recently completed or were in the process of conducting outreach to increase participation in SSI (Silverstein and Puma, 1992). Therefore, according to program staff, residents of these areas had already been saturated with outreach information and those most likely to respond had already done so. The remaining nonparticipants were those hardest to reach and least likely to be affected by mass media messages and community activities. Efforts to enroll these "hard-to reach" seniors, who most likely were homebound and/or living in isolated rural areas would have required quite labor-intensive efforts such as door-to-door canvassing, home visits, and transportation assistance. Yet most of the sites did not conduct intensive, one-on-one outreach, citing limited staff and resources. Furthermore, the sites that did conduct door-to-door canvassing did not always make direct contact with elderly residents; some simply left literature in mailboxes. Rural sites, where door-to-door outreach would appear to offer great promise for reaching isolated elderly, chose not to use this strategy, indicating that the time and cost would have exceeded the potential benefits (Silverstein and Puma, 1992).

The broad-based nature of media messages also may have been a factor in the campaign's limited impact. Campaign messages were not specifically tailored to the low-income elderly, responding directly to their particular needs, concerns, problems, and beliefs. Furthermore, many of the public service announcements and televised interviews with outreach staff were broadcast on cable television, which may not have been affordable to low-income seniors. And, indeed, many of those responding to the media campaign had incomes and assets too high to qualify for federal assistance. By conducting baseline surveys and/or focus groups with low-income elderly in the outreach sites, AARP project teams could have gained valuable insights about the characteristics of the campaign audience and thus could

have developed messages and selected communication channels more appropriately targeted to needy senior citizens.

Currently, AARP is conducting the Public Benefits Outreach Study, a two-year, nationwide pilot project that incorporates key findings from its previous efforts. The project, which seeks to increase enrollment in QMB as well as the programs targeted in the 1989-91 campaign, involves testing a variety of outreach approaches. To encourage initiation of local outreach efforts, AARP is distributing comprehensive "how-to" kits (including a video, fact sheets in eight languages, volunteer training manuals, prescreening tools, and instructional manuals) providing outreach guidelines for state agencies and community organizations. In addition, in rural areas, the organization is testing the impact of different direct mail strategies, to determine the effectiveness of sending postcards and letters with program information versus those listing a toll-free benefits information hotline staffed by trained volunteers. In urban areas, AARP is using community-level partnerships to experiment with a variety of outreach methods, such as establishing phone banks to call potential beneficiaries, coordinating television media campaigns, stationing outreach workers in community settings, providing enrollment incentives through coupons, and using hospital staff to identify potential beneficiaries. In these programs, local nonprofit organizations work closely with the Social Security Administration and the local welfare office. AARP is also working with groups of its own volunteers to conduct a Food Stamps radio blitz, promote the AARP outreach kit, and train volunteers from health care advocacy groups to conduct QMB outreach (Sternberg, 1993).

AARP plans to evaluate all of these efforts and to prepare a final report at the conclusion of the project in late 1994. Relative success rates of the various outreach strategies will help the organization determine the types of projects to continue and expand (Sternberg, 1993).

6.4 State Outreach Programs and QMB Enrollment Rates

As indicated in the previous section, state approaches to QMB outreach have varied substantially. To determine whether particular state QMB outreach activities were associated with higher QMB enrollment rates, Project HOPE compared its state-by-state enrollment data (1994) with information on the nature and extent of state QMB outreach activities (APWA, 1993). Based on findings from our literature review, we defined state outreach programs as "aggressive" if they included all three of the following:

- outstationing;
- working with community groups; and
- coordinating with aging networks.

States with "aggressive" QMB outreach projects included: Arkansas; Florida; Georgia; Hawaii; Louisiana; North Carolina; Tennessee; and Wisconsin (See Table 6.5 at end of chapter). Overall, among the "aggressive" states, 49 percent of those eligible for QMB were enrolled, while in the "non-aggressive" states, just 40 percent of QMB eligibles were enrolled (See Table 6.6). These findings suggest that outstationing and coordination with community groups and aging networks could be particularly effective strategies for increasing QMB enrollment rates. Further research is necessary to determine the specific methods states have used to coordinate with community networks, and to determine why these strategies have contributed to increased enrollment rates.

To test the effect of state outreach programs on QMB participation rates more formally, we added a number of outreach variables to the basic logistic regression model outlined in Chapter 4. Using the basic model as a starting point, we sought to determine whether holding all other demographic variables constant, seniors living in states with outreach programs, characterized as aggressive or otherwise, were more likely to participate in the QMB program. The regression results of the four outreach regression models are

Table 6.6 Total QMB Enrollment Rates: States with Aggressive¹ vs. Non-Aggressive Outreach Strategies

	Aggressive States	Non-Aggressive States	Total
(in millions)			
Total Eligible	0.79	3.88	4.67
Total Enrolled	0.39	1.54	1.93
Percent Enrolled	50%	40%	41%

Sources:

American Public Welfare Association, Draft Report, Qualified Medicaid and Medicare Beneficiaries: Report of a Survey, Washington, D.C., September 1993.

Project HOPE's analysis of QMB supplement to the Medicare Current Beneficiary Survey, 1993.

¹ The American Public Welfare Association (APWA) recently conducted a survey on state outreach programs aimed at increasing QMB enrollment (Qualified Medicaid and Medicare Beneficiaries: Report of a Survey, Washington, D.C., September 1993). The organization defined eight categories of outreach activities: mailings; PSAs; outstationing; contact through community groups; press activities; brochure distribution; contact through aging networks; and "other." Project HOPE is defining "aggressive" outreach as encompassing three of these categories: outstationing; contact through community groups; and contact through aging networks. This definition is based on research findings that activities at the grass roots level, through organizations familiar to the target population, are likely to be more effective in increasing program enrollment than are mass media messages and distribution of printed material not accompanied by interpersonal communication. Furthermore, outstationing facilitates enrollment, as it provides services in convenient neighborhood locations and removes the stigma involved with visiting a welfare office.

presented in Table 6.7. For brevity, we have not reported the coefficients of the other independent variables included in these models.

We first added a dummy variable for state aggressiveness in outreach, as defined above. This result is presented as Model 1 in the table. Here we found modest evidence that aggressive outreach programs altered participation rates. Seniors living in states with aggressive outreach programs had higher QMB participation rates, but the effect was not statistically significant at conventional levels.

We have also reported the results from other logistic regression models that allow for a more general test of the effectiveness of outreach programs. In Model 2 of Table 6.7, we have included a count of the number of different types of outreach programs initiated by the states. The simple count of programs had a large and statistically significant effect on participation. The marginal effect indicated that adding an additional outreach program increases participation rates by 3.5 percentage points.

This effect was, however, not linear in the number of programs. In Model 3, we added indicator variables for one, two, three, four, or five or more programs, with the reference category being states with no outreach programs. The results for this model suggest that states which try numerous programs tend to have the highest QMB participation rates. States with three or more programs had participation rates about 16 percentage points higher than states with no outreach initiatives.

Last, we sought to determine whether particular outreach programs were more effective than others. In Model 4, we added dummy variables for each of the seven outreach programs listed in Table 6.4. Almost all programs increased QMB participation, but only public service announcements and aging networks produced statistically significant effects.

Table 6.7: Effects of Outreach on QMB Participation
Normalized Logistic Coefficients and Standard Errors(a)

Independent Variable	Model (1)	Model (2)	Model (3)	Model (4)
State Aggressiveness	0.098 (0.062)			
Total #Programs		0.035*** (0.009)		
One Program (b)			0.081 (0.080)	
Two Programs (b)			0.088* (0.048)	
Three Programs (b)			0.155** (0.065)	
Four Programs (b)			0.176*** (0.059)	
Five Programs (b)			0.168*** (0.053)	
Mailings				0.006 (0.041)
PSA				0.206*** (0.071)
Outstations				-0.008 (0.042)
City Groups				0.018 (0.054)
Press Release				0.066 (0.049)
Brochures				0.003 (0.041)
Aging Networks				0.091** (0.045)

Other independent variables include age, age squared, the natural log of income plus variables for self reported health status, race, ethnicity, sex, region of country, urbanicity, marital status, educational level and home ownership.

* Significant at the 10% level.

** Significant at the 5% level.

*** Significant at the 1% level.

(a) The logistic coefficients and standard errors are multiplied by $p^*(1-p^*)$ where p^* is the mean of the dependent variable. In these models $p^* = 0.4132$. The normalized coefficients are estimates of the change in the probability of enrolling in the QMB program given a change in the independent variable. All estimation procedures are weighted.

(b) The reference group is no program.

6.5 Lessons Learned from Past Efforts

A multitude of federal, state, and private initiatives have sought to increase enrollment of low-income senior citizens in public benefits programs. Based on the information available, it is difficult to draw absolute conclusions about appropriate outreach strategies, as most outreach projects have not been rigorously evaluated. Descriptions of project outcomes, when available, are often anecdotal, lacking specific data to support general conclusions. Even when data are provided, critical information, such as the percentage of those eligible for benefits who applied and enrolled during and after implementation of outreach programs, is often missing. Furthermore, none of the projects examined for this study sought to determine the strategies which are most cost-effective. Such information would help policymakers make difficult decisions about resource allocation in an era of tight budget constraints. Evaluations of several major outreach programs are currently underway, and additional evaluation will be needed as new programs are initiated. In the future, it would be useful for analysts to examine the issue of cost-effectiveness as well as efficacy. .

Despite the limitations of the available data, it is possible to make some basic generalizations:

- **It is often difficult to enroll low-income seniors in public benefits programs.** Barriers to enrollment include lack of awareness of the programs; social isolation; lack of transportation; difficulty in filling out forms; and stigma.
- **Communication with low-income groups should not be limited to mass media campaigns.** Families USA's Project SIGN-UP and AARP's comprehensive outreach demonstration found that responses to mass media appeals were greatest among those with incomes and assets too high to qualify for federal assistance. Broadcasting campaign messages on cable television may be ineffective, as many low-income elderly cannot afford cable service.
- **Outreach is most effective when narrowly targeted to specific low-income subpopulations.** Social Security Administration

staff has noted the importance of designing programs to reach specific racial/ethnic groups or persons with particular disabilities. Watkins and Gonzales found that the credibility of outreach efforts was enhanced by using outreach workers of the same racial/ethnic group as those in the target population.

- **Grass-roots organizing and interpersonal contacts tend to work well.** New York State officials involved in SSI outreach report that the most effective programs provide information through churches and community centers and involve door-to-door canvassing.
- **Helping those potentially eligible through the enrollment process can be critical.** Findings from Food Stamps hotlines operated by the Ad Council and Project Bread, as well as from the Ohio BOSS software demonstration project, demonstrate the importance of following up with individuals prescreened for eligibility and helping those potentially eligible to gather necessary documentation. Transportation assistance is also frequently needed.
- **"Outstationing" can help remove stigma.** AARP's comprehensive outreach demonstration found that establishing application sites outside the Medicaid or "welfare" office (i.e., in local libraries or community centers) can help remove the embarrassment often associated with applying for public assistance.

These findings suggest that effective outreach is necessarily quite labor-intensive and thus expensive. To maximize both efficacy and cost-effectiveness, it may be helpful to conduct preliminary research, as recommended by Stuen (1985), such as focus groups, small-scale surveys, or individual in-depth interviews, to increase understanding of the target population's needs, as well as their values, problems and attitudes toward public benefits. Such enhanced understanding is critical to ensure that campaign materials both reflect and respond to the unique characteristics of the individuals targeted.

6.6 Comments from Outreach Professionals: Final Meeting of the Technical Advisory Panel

In the final phase of our QMB research, we met for a second time with a technical advisory panel of outreach professionals, to present our study findings and discuss models for future QMB outreach. Panel members' comments both confirmed our findings on public benefits outreach projects and provided fresh perspectives on issues associated with QMB outreach. The following is an overview of topics discussed at this meeting.

Problems Associated with Past and Ongoing Outreach Efforts

Organizations conducting outreach often have undertaken an intensive, one-time effort to enroll eligible populations. However, our technical advisory group agreed that to have a substantial and lasting impact on program enrollment, organizations must make a long-term commitment to conduct outreach activities on a continuing basis. Another major problem is that many public benefits outreach programs have been conducted in isolation, without coordination among groups seeking to achieve similar objectives. As a result, valuable resources have been wasted on duplication of effort, and target populations have become confused by a cacophony of outreach messages. Panel members also noted that the lack of program knowledge among agency caseworkers has hampered the effectiveness of public benefits outreach projects.

Alternative Strategies for Future Projects

■ Problems with Some Techniques

Panel members identified several outreach strategies which have proven ineffective. Public communication campaigns which have relied solely on the mass media and/or mass mailings have not achieved their desired objectives. Rather, they have "flooded" agencies with inquiries from people who do not qualify for the advertised benefits. This problem has also occurred when mass media messages were generalized "one-size-fits-all" slogans, rather

than carefully worded messages developed through research and consultation with members of the target population. Phone-banking campaigns have also been ineffective, as individuals have been annoyed by unsolicited phone calls and have assumed that callers were trying to sell commercial products.

- **The Need for Multi-Faceted Efforts**

In discussing strategies which can be effective, panel participants agreed that there is "no magic bullet." Therefore, they said, outreach projects should utilize a variety of communication strategies, including several different types of media, as well as one-on-one contacts. Because people are often confused about their eligibility and intimidated by agency procedures, panel members stressed the need for "hands-on" assistance throughout the eligibility screening and enrollment process. Individuals may need assistance locating necessary documents, filling out forms, and traveling to the appropriate benefits office. Outreach activities should also be designed to overcome the stigma often associated with public benefits. There is no single, clear-cut way to accomplish this goal, however. At times, coordinating public benefits outreach with ongoing events such as health fairs or senior center activities has worked well. However, many senior citizens have been reluctant to undergo eligibility screening in public places where their more affluent friends may see them. To overcome this problem, it may be helpful to conduct outreach in settings where everyone present is in the same income category, such as at U.S. Department of Agriculture commodity distribution sites.

- **Experimentation with Different Techniques**

The American Association for Retired Persons (AARP) has launched the Public Benefits Outreach Study to compare the effectiveness of different outreach communication techniques. Because the project is ongoing, there are no conclusive evaluation data available. However, preliminary assessments indicate that several strategies may be effective in eliciting responses from low-income seniors. These include: providing small gift items and coupons as

incentives for people to inquire about benefits; mailing pamphlets that briefly describe programs and provide phone numbers for people to call for more information; and outstationing in senior centers.

- **The Community Coalition Model**

A recent QMB outreach campaign in Tennessee provides an example of how public and private entities on the state and local level can work together to increase program enrollment. Tennessee's QMB outreach coalition included local chapters of senior citizens' advocacy groups; legislators' offices; religious organizations; Area Agencies on Aging; legal services organizations; and medical social workers. While the state does not have data on changes in QMB enrollment which resulted from this project, anecdotal evidence indicates that the coalition model worked successfully to ensure broad dissemination of outreach messages, to increase awareness of the QMB program, and to facilitate cooperation among organizations serving the low-income elderly. As part of the project, which ran from September 1991-June 1992, the state Medicaid office developed a simplified, one-page QMB application form. This change should make it easier to enroll in the program and thus should have a long-term, positive impact on QMB participation in Tennessee.

- **Use of Community Members to Identify Potential Beneficiaries**

Advisory group members agreed that outreach efforts can be enhanced through the participation of community members who interact with low-income senior citizens on a regular basis. They mentioned that individuals such as meter readers; durable medical equipment suppliers; health care professionals; home care agencies; and local Meals on Wheels workers often are aware of circumstances indicating that individuals may be eligible for public benefits. Therefore, panel members noted, campaign planners could establish procedures through which these types of community-based workers could link needy people with appropriate outreach workers or agency staff.

■ The Use of Elderly Outreach Workers

The National Caucus and Center for Black Aged (NCBA) has utilized a "matching model" of entitlement program outreach. Its project, supported through the U.S. Department of Labor's Seniors in Community Service Program, pays senior citizens to conduct outreach for a variety of federal benefits programs, including QMB. The workers, who receive comprehensive training on entitlement laws and regulations, provide eligibility screening and enrollment assistance for low-income seniors in seven states and the District of Columbia. Senior citizens have been quite receptive to contacts from elderly outreach workers. NCBA representatives indicate that this "matching" tends to put low-income seniors at ease, so that they are willing to share information about their income and assets. The program has been very successful; its application-to-enrollment ratio is approximately 93 percent. Yet the project is quite labor intensive and costly; therefore, it may be difficult for other groups to replicate.

The Need for a Compelling Message

Panel members discussed the importance of developing compelling messages to motivate low-income seniors to inquire about QMB enrollment or to seek application assistance. They recognized that campaign planners may have erroneous perceptions about the types of messages which are easy to understand and which are likely to elicit a response. Therefore, it may be helpful to consult with public relations professionals or to convene focus groups prior to initiating outreach activities.

Unintended Consequences of Single-Program Outreach

The advisory group noted that understanding federal entitlements can be difficult, as each program has its own regulations and eligibility criteria. Furthermore, there are currently no formal inter-agency systems for sharing data on applicants' eligibility for different programs. As a result, well-intentioned outreach workers may enroll clients in one program

while inadvertently making them ineligible for others which provide more generous benefits. For example, by accepting QMB benefits, some people may be deemed ineligible for federal housing subsidies. Therefore, several panel members recommended that outreach campaigns take a comprehensive approach to eligibility screening. Rather than focusing on a single program, eligibility workers should be trained to gather data needed for all of the major entitlements, and should seek to determine the program or programs which would provide clients with the greatest level of assistance.

Recommended Agency Changes

Several advisory group members indicated that it would be useful to coordinate outreach efforts with changes in agency staff training and procedures. In addition to improving the education of caseworkers, they suggested that agencies simplify their eligibility forms and develop systems to screen people automatically for income-based assistance programs when they apply for other federal benefits. In addition, they recommended that agencies share program data on low-income clients to ensure that they receive all benefits for which they are eligible.

Table 6.1 Outreach for the Medicaid and QMB Programs

Entity Conducting Outreach	Outreach Activities	Outcome
<u>Federal Government</u> U.S. Department of Health and Human Services, Health Care Financing Administration	<ul style="list-style-type: none">articles in publications read by seniorsQMB leaflets, fact sheets, distribution of a PSAQMB information on the toll-free Medicare hotlineinformation in the <u>Medicare Handbook</u>administration of Information, Counseling, and Assistance (ICA) grants to all statesoutreach kits with video and shortened screening formspecial mailings	<ul style="list-style-type: none">most unknownICA program currently being evaluated30 percent response rate to special mailings (resulting in approximately 66,000 additional QMBs enrolled since February 1993)
<u>State Governments</u> Arkansas	<ul style="list-style-type: none">PSAsposters and flyersvoice mailboxpresentations to community organizations	<ul style="list-style-type: none">unknown

Entity Conducting Outreach	Outreach Activities	Outcome
Delaware	<ul style="list-style-type: none"> ● assistance with completing applications ● transportation to welfare offices 	<ul style="list-style-type: none"> ● unknown
Florida	<ul style="list-style-type: none"> ● phone line providing information on benefits programs ● automated eligibility determination system ● mailing Medicaid eligibility information with utility bills ● placing staff in hospitals to help elderly patients apply 	<ul style="list-style-type: none"> ● unknown
New York	<ul style="list-style-type: none"> ● home visits ● application assistance 	<ul style="list-style-type: none"> ● unknown
North Dakota	<ul style="list-style-type: none"> ● hotlines 	<ul style="list-style-type: none"> ● unknown
Pennsylvania	<ul style="list-style-type: none"> ● home visits ● notices 	<ul style="list-style-type: none"> ● Over a three-year period, home visits identified 472 frail seniors over age 75 potentially eligible for assistance.
South Carolina	<ul style="list-style-type: none"> ● flyers 	<ul style="list-style-type: none"> ● unknown
Tennessee	<ul style="list-style-type: none"> ● training public housing rent collection staff and staff at commodity distribution sites to identify individuals potentially eligible 	<ul style="list-style-type: none"> ● unknown

Entity Conducting Outreach	Outreach Activities	Outcome
Wisconsin	<ul style="list-style-type: none"> ● benefit specialists in each county ● home visits ● presentation at senior centers 	<ul style="list-style-type: none"> ● unknown
<u>Private Organizations</u> National Council of Senior Citizens	<ul style="list-style-type: none"> ● articles in <u>Senior Citizen News</u> ● newsletter articles ● special mailings ● discussion at club meetings 	<ul style="list-style-type: none"> ● unknown
National Indian Council on Aging	<ul style="list-style-type: none"> ● training elderly tribe members to identify seniors potentially eligible and conduct screening ● translation of benefits information ● transportation assistance ● help with agency interviews 	<ul style="list-style-type: none"> ● unknown
United Seniors Health Cooperative	<ul style="list-style-type: none"> ● BOSS screening software; referral to appropriate agencies 	<ul style="list-style-type: none"> ● In a demonstration project in three Ohio counties, 22 percent of 160 senior screened ultimately applied for benefits.

Sources:

American Association of Retired Persons (AARP), Medicaid: A Review of Participation Rates and Outreach Activities, Prepared for AARP by the Center on Budget and Policy Priorities, Washington, D.C., 1991.

Health Care Financing Administration, 1993.

National Council of Senior Citizens, 1993.

United Seniors Health Cooperative, 1993.

Table 6.2 Outreach for the SSI Program

Entity Conducting Outreach	Outreach Activities	Outcome
Federal Government U.S. Department of Health and Human Services, Social Security Administration	<ul style="list-style-type: none">mailings;grants to social service providers, advocacy groups, and state government agencies in 49 communities across the countrypilot project with Department of Veterans Affairs targeting the homeless chronically mentally ill	<ul style="list-style-type: none">For one-time mailings, one percent of those notified subsequently applied, and 0.7 percent received benefits.Evaluation of grant program is ongoing.Anecdotal reports suggest that programs should be targeted to specific low-income subpopulations.Evaluation of pilot project planned for the future.
State Governments Florida	<ul style="list-style-type: none">hotlineregional outreach planspublicity through the mass media and agency newslettersflyers	<ul style="list-style-type: none">unknown
Maryland	<ul style="list-style-type: none">utility bill insertsarticles in company newslettersreferrals from utility workers	<ul style="list-style-type: none">unknown

65-9

Entity Conducting Outreach	Outreach Activities	Outcome
New York	<ul style="list-style-type: none"> \$2 million in grants to Area Agencies on Aging and community organizations 	<ul style="list-style-type: none"> Of those reached in the 1991-92 grant cycle, approximately four percent ultimately received SSI benefits.
<u>Private Organization</u> Families USA	Project SIGN-UP targeting low-income seniors in Boston -- included communication through the mass media as well as community-based, interpersonal channels	<ul style="list-style-type: none"> Of 735 individuals screened, 46.5 percent were found to be potentially eligible, and 28 percent ultimately enrolled.

Sources:

American Association of Retired Persons (AARP), Supplemental Security Income: A Review of Participation Rates and Outreach Activities, Prepared for AARP by the Center on Budget and Policy Priorities, Washington, D.C., 1991.

Jerry, Donna and Villers, Katherine, Project SIGN-UP: A Pilot Project for Demonstration of Supplemental Security Income (SSI) Program Outreach Targeting Increased Enrollment of Minority Aged and Older Disabled Populations, Families USA, Boston, MA, September 1992.

Social Security Administration, Social Security Bulletin, 51(1): 12-17, January 1988.

Social Security Administration, 1993.

Table 6.3 Outreach for the Food Stamps Program

Entity Conducting Outreach	Outreach Activities	Outcome
<u>Federally Coordinated Public/Private Partnership</u> Project FIND (coordinated by the White House and federal agencies)	<ul style="list-style-type: none">mass mailings to low-income seniors, followed by Red Cross contact with those who returned postcards, as well as application assistance	<ul style="list-style-type: none">Lack of follow-up by Red Cross volunteers; no systematic coordination between volunteers and Food Stamp offices
<u>State Government</u> Missouri	<ul style="list-style-type: none">survey of Food Stamp recipients, advocates, and caseworkers to examine reasons for nonparticipationnewspaper articlesinformational leafletsradio and television PSAsprescreening by volunteersmeetings with welfare caseworkersvideo distributed to churches, community groups, and talk shows	<ul style="list-style-type: none">From 1987-1989, number of households receiving benefits increased from 138,000 to 154,000.
<u>Private Organizations</u> Damiano Center in Duluth, Minnesota	<ul style="list-style-type: none">meetings with grocery store owners to discuss economic value of Food Stamps and remove stigmause of Food Stamp recipients as volunteers to identify those potentially eligible	<ul style="list-style-type: none">No evaluation conducted; number of households receiving Food Stamps stayed constant during the project period although unemployment dropped substantially.

Entity Conducting Outreach	Outreach Activities	Outcome
The Advertising Council	<ul style="list-style-type: none"> • radio and TV PSAs; toll-free information line 	<ul style="list-style-type: none"> • Of 300,000 individuals who called the hotline, nine percent subsequently enrolled.
Project Bread	<ul style="list-style-type: none"> • ongoing Hunger Hotline that screens callers for potential eligibility and tracks them through the application process; publicity of hotline through the media and community organizations 	<ul style="list-style-type: none"> • Evaluations in 1986 and 1987 found that 20 percent of hotline callers ultimately received benefits.

Source: American Association of Retired Persons (AARP), Food Stamps: A Review of Participation Rates and Outreach Activities, Prepared for AARP by the Center on Budget and Policy Priorities, Washington, D.C., 1991.

Table 6.5 Aggressiveness¹ of QMB Outreach, by State

State	Aggressive	Non-Aggressive
Alabama		X
Alaska		X
Arizona		X
Arkansas	X	
California		X
Colorado		X
Connecticut		X
Delaware		X
District of Columbia*		X
Florida	X	
Georgia	X	
Hawaii	X	
Idaho		X
Illinois		X
Indiana		X
Iowa		X
Kansas		X

¹ The American Public Welfare Association (APWA) recently conducted a survey on state outreach programs aimed at increasing QMB enrollment (Qualified Medicaid and Medicare Beneficiaries: Report of a Survey, Washington, D.C., September 1993). The organization defined eight categories of outreach activities: mailings; PSAs; outstationing; contact through community groups; press activities; brochure distribution; contact through aging networks; and "other." Project HOPE is defining "aggressive" outreach as encompassing three of these categories: outstationing; contact through community groups; and contact through aging networks. This definition is based on research findings that activities at the grass roots level, through organizations familiar to the target population, are likely to be more effective in increasing program enrollment than are mass media messages and distribution of printed material not accompanied by interpersonal communication. Furthermore, outstationing facilitates enrollment, as it provides services in convenient neighborhood locations and removes the stigma involved with visiting a welfare office.

Kentucky		X
Louisiana	X	
Maine*		X
Maryland		X
Massachusetts		X
Michigan		X
Minnesota		X
Mississippi		X
Missouri		X
Montana		X
Nebraska		X
Nevada		X
New Hampshire		X
New Jersey		X
New Mexico		X
New York		X
North Carolina	X	
North Dakota		X
Ohio		X
Oklahoma		X
Oregon		X
Pennsylvania		X
Puerto Rico*		
South Carolina		X
South Dakota		X
Tennessee	X	
Texas		X
Utah		X
Vermont		X

Virginia		X
Washington		X
West Virginia		X
Wisconsin	X	
Wyoming		X

* Did not respond to APWA survey. Project HOPE staff conducted brief telephone interviews with state officials to determine the appropriate outreach category.

CHAPTER 7

CONCLUSIONS AND IMPLICATIONS

7.1 Major Findings

The study contains several important findings:

1. Many eligible beneficiaries are still not enrolled in the QMB program.
2. Those who are enrolled tend to be those most in need of the program.
3. Nonparticipating eligibles are not enrolling because: they do not believe they need the program; they do not believe they qualify; or because they are not aware of the program.
4. Successful outreach programs should include interpersonal contacts, enrollment assistance, and coordination with community groups and aging networks.

7.2 Policy Implications

Identifying and enrolling eligible individuals is a problem common to all means-tested government assistance programs. Legislating the eligibility of certain individuals does not ensure their participation. Even the most aggressive outreach efforts do not reach all eligible individuals. Many individuals do not receive or comprehend outreach information, and some who suspect they are eligible have trouble accessing the system. Others refuse to enroll because of the stigma of welfare.

These problems are exacerbated among the low-income elderly because of the population's advanced age and more limited mobility. Moreover, the QMB-eligible population tends to be a poorly educated and socially isolated group.

Our findings suggest that those with the lowest incomes and in poorest health have the highest enrollment rates. Those in contact with federal or state government programs, such as Medicaid, SSI, or other welfare assistance, are more likely to participate in the QMB program. Thus, to some extent the system is working.

However, many needy individuals still are not participating in the program. Furthermore, our findings indicate that beneficiaries are not well-informed about the program. To increase knowledge about and participation in the QMB program, outreach efforts should involve ongoing activities with information targeted to those most in need.

7.3 Areas for Further Research

Our results suggest that a number of areas would be fruitful for further research. First, it would be useful to link data on enrollment to information on beneficiaries' actual out-of-pocket costs for health care. For example, it would be helpful to know the percentage of after-tax income that enrollees and non-enrollees devote to medical care. Another important question involves whether nonparticipating eligibles refrain from using medical services in an attempt to avoid cost-sharing requirements.

Second, it would be useful to link information from claims data on the actual utilization and expenditures of QMB eligibles. Doing so would provide a more complete profile of the health experiences of QMB-eligibles and enable us to examine more precisely the experience of enrollees and non-enrollees. For example, controlling for factors such as age and sex, do enrollees use more medical services and incur higher expenditures than non-enrolled eligibles? Is there any discernible differential between the groups in patient outcomes such as mortality or morbidity?

Third, a more detailed investigation of survey questions on income is warranted. Our study found that reported income varied considerably depending on how questions were framed. This had important consequences for the size of the eligible

population and thus for our overall results on enrollment rates. It would be useful to investigate precisely how responses vary with the framing of questions, and to conduct validity and reliability tests to discern which of the questions are most accurate.

Fourth, it would be useful to examine whether QMB enrollment rates have changed over time. Furthermore, do the same individuals continue to receive benefits? Fifth, a slight expansion of our study would permit an investigation of participation rates in the Specified Low-income Medicare Beneficiary (SLMB) program.¹

Sixth, it would be useful to investigate further the motivations of enrollees and nonenrollees. In particular, it would be useful to investigate the process by which eligibles actually enroll in the program. Are they enrolling by themselves or with the aid of a family member, friend, or outreach worker?

Finally, more systematic evaluations of outreach initiatives are needed. Most outreach efforts have not been rigorously analyzed. Demonstrations with strict evaluation components would be useful. These evaluations should be designed to examine changes in enrollment patterns over time.

¹The SLMB program requires Medicaid to pay the Part B premiums for beneficiaries with incomes between 100 and 120 percent of the federal poverty line, and assets below a specified threshold.

REFERENCES

American Association of Retired Persons (AARP), (a) Medicaid: A Review of Participation Rates and Outreach Activities, Prepared for AARP by the Center on Budget and Policy Priorities, Washington, D.C., 1991.

AARP, (b) Supplemental Security Income: A Review of Participation Rates and Outreach Activities, Prepared for AARP by the Center on Budget and Policy Priorities, Washington, D.C., 1991.

AARP, (c) Food Stamps: A Review of Participation Rates and Outreach Activities, Prepared for AARP by the Center on Budget and Policy Priorities, Washington, D.C., 1991.

AARP, (d) Low-Income Home Energy Assistance Program (LIHEAP): A Review of Participation Rates and Outreach Activities, Prepared for AARP by the Center on Budget and Policy Priorities, Washington, D.C., 1991.

AARP. Supplemental Security Income Demonstration Outreach Project. Final Report submitted to the Commonwealth Fund Commission on Elderly People Living Alone, Washington, D.C., 1988.

American Public Welfare Association, "Issue Brief: State Outreach to Qualified Medicare Beneficiaries," Washington, D.C., August 1991.

American Public Welfare Association, Draft Report, Qualified Medicaid and Medicare Beneficiaries: Report of a Survey, Washington, D.C., September 1993.

Bendick, M., "Failure to Enroll in Public Assistance Programs," Social Work, 25: 268-274, 1980.

Berk, M. and G. Wilensky, G., "Health Care of the Poor Elderly: Supplementing Medicare," The Gerontologist, 25(3): 311-314, 1985.

Blank, R.M., "The Effect of Medical Need and Medicaid on AFDC Participation," The Journal of Human Resources, 24(1): 54-88, 1989.

Bottome, A., Director of Community Development, Families USA, Boston, MA, Private personal communication, October 25, 1993.

Coe, R., "Nonparticipation in Welfare Programs by Eligible Households: The Case of the Food Stamp Program," Journal of Economic Issues, 17(4): 1035-56, 1983.

Congressional Research Service, Medicaid Source Book, 1988.

Crawford, B., Staff Director, SSI Outreach Branch, Social Security Administration, Baltimore, MD, Private personal communication, October 25, 1993.

Dunlop, B.D., Wells, J.A., and Wilensky, G., "The Influence of Source of Insurance Coverage on the Health Care Utilization of the Elderly." Journal of Health and Human Resources Administration, 11: 285-311, 1989.

Families USA, The Secret Benefit: The Failure to Provide Medicare Buy-In to Poor Seniors, Washington, D.C., 1991.

Families USA, The Medicare Buy-In: Still A Government Secret, Washington, D.C., March 1992.

Families USA, The Medicare Buy-In: A Promise Unfulfilled, Washington, D.C., March 1993.

Federation for Community Planning, Senior Benefits Eligibility Screening Service: Demonstration Project Final Report, Cleveland, Ohio, October 1990.

Health Care Financing Administration, State Medicaid Manual, Part 3: Eligibility, 1991.

Health Care Financing Administration, "1992 Health Insurance Information, Counseling, and Assistance Grants Program," Grant announcement, Baltimore, MD, 1992.

Health Care Financing Administration, Draft testimony before the Ways and Means Subcommittees on Social Security and Health and Human Resources, U.S. House of Representatives, Washington, D.C., March 26, 1992.

Hollenbeck, D. and Ohls, J.C., "Participation Among the Elderly in the Food Stamp Program," The Gerontologist, 24(6): 616-21, 1984.

Hosmer, D.W., and Lemeshow, S., Applied Logistic Regression, New York: John Wiley and Sons, 1989.

ICF, Inc., Barriers to Participation in the Supplemental Security Income Program: An Assessment of Potential Demonstration Sites. Prepared for AARP, Washington, D.C., 1987.

ICF, Inc., Documentation and Assessment of the AARP-SSI Outreach Demonstration. Prepared for AARP, Washington, D.C., 1988.

Jacobson, J., Director, Council on Older Persons, Federation for Community Planning, Cleveland, Ohio, Private personal communication, January 3, 1994.

Jerry, D. and Villers, K., Project Sign-Up: A Pilot Project for Demonstration of Supplemental Security Income (SSI) Program Outreach Targeting Increased Enrollment of Minority Aged and Older Disabled Populations, Families USA, Boston, MA, September 1992.

Kushler, M.G. and Davidson, W.S., "Alternative Models of Outreach,: An Experimental Comparison," The Gerontologist, 18(4): 355-362, 1978.

Lang, E., Public Affairs Specialist, Office of Beneficiary Services, Associate Administrator for Communications, Health Care Financing Administration, Baltimore, MD, Private personal communication, October 14, 1993.

Lewin/ICF, Elderly Persons Eligible for and Participating in the Supplemental Security Income Program: Estimates for 1975 through 2020, Final Report to ASPE, HHS, Washington, D.C., 1989.

Louis Harris and Associates. Problems Facing the Elderly Living Alone: Americans Living Alone, conducted for the Commonwealth Fund Commission on Elderly People Living Alone, New York, NY, 1987.

Louis Harris and Associates, Inc., Strategies to Increase Participation in the Supplemental Security Income Program: Follow-Up Study of Poor Elderly People, Prepared for AARP under a grant from the Commonwealth Fund Commission on Elderly People Living Alone, New York, NY, February 1988.

Mak, P., President, Brooklyn Chinese-American Association, Brooklyn, New York, Private personal communication, November 11, 1993.

McMillan, A. et al., "A Study of the Crossover Population: Aged persons Entitled to Both Medicare and Medicaid." Health Care Financing Review, 4(4): 19-46, 1983.

Mooney, B., Supplemental Security Outreach Program: New York State Office for the Aging, Final Report, Albany, NY, March 1993.

Mooney, B., Project Manager, SSI Outreach Program, New York State Office for Aging, Albany, NY, Private personal communication, October 26, 1993.

Mondin, C., Communications Manager, United Seniors Health Cooperative, Washington, D.C., Private personal communication, October 19, 1993.

National Indian Council on Aging, Access: A Demonstration Project, Entitlement Programs for Indian Elders, 1982.

Sarah Shuptrine and Associates, State Implementation of the Medicare Catastrophic Coverage Act of 1988, Study conducted for the Villers Foundation, 1989.

Shipley, J., Public Affairs Specialist, Office of Public Liaison, Division of Beneficiary Services, Health Care Financing Administration, Baltimore, MD, Private personal communication, January 11, 1994.

Silverstein, G. and Puma, M., Evaluation of the AARP Outreach Demonstration Projects, Abt Associates, Bethesda, MD, April 1992.

Social Security Administration, Social Security Bulletin, 51(1): 12-17, January 1988.

Sparacino, M., Health Insurance Specialist, the Medicaid Bureau, Health Care Financing Administration, Baltimore, MD, Private personal communication, October 15, 1993.

Sparacino, M., Private personal communication, Feruary 3, 1994.

Sternberg, J., Senior Program Specialist, Consumer Affairs Department, American Association of Retired Persons, Private personal communication, October 26, 1993.

Stine, W., "The Effect of Local Government Outreach Efforts on the Recipiency of Selected Medicaid Programs, Inquiry, 28: 161-8, 1991.

Stone, R.I., The Medicare Current Beneficiary Survey: A Database for the 1990's and Beyond, Prepared for the Health Care Financing Administration under Cooperative Agreement No. 99-C-99168/3-04, Project HOPE Center for Health Affairs, Bethesda, MD, July 15, 1993.

Stuen, C., "Outreach to the Elderly: Community-Based Services," Journal of Gerontological Social Work, 8(3/4):85-96, Spring/Summer 1985.

Watkins, T.R. and Gonzales, R., "Outreach to Mexican-Americans," Social Work, 27(1): 68-73, January 1982.

Young, C. et al., "Organizational Volunteers for the Rural Frail Elderly: Outreach, Casefinding, and Service Delivery," The Gerontologist, 26(4): 342-344, 1986.

APPENDIX A

EXPLORING THE ACCURACY OF THE SAMPLE

A.1 Comparison between Project HOPE and Families USA

A lingering question involves why our estimate of the QMB enrollment rate (41 percent) differs from that reported in the Families USA study (53 percent). In this appendix we explore the discrepancy.

A slight difference may be attributable to the different time-frames of the studies. In the Project HOPE study, the eligible sample was estimated for the summer of 1992 (and the Medicare Buy-Ins in the spring of 1993). The Families USA reports examined eligibles and buy-ins in the spring of 1991 and 1992, respectively (Families USA, 1991; 1992).

The major source of difference, though, is the surveys employed to estimate the QMB-eligible population. The Families USA study used the Current Population Survey (CPS) to identify a population of elderly individuals with incomes below the poverty line. It then used the 1984 Survey of Income and Program Participation (SIPP) data adjusted to 1991 to remove from the sample those individuals not meeting the asset criteria. In contrast, the Project HOPE study identified eligible beneficiaries using the Income and Asset Supplement of the Medicare Current Beneficiary Survey. (Note, though, that both studies used the Medicare Buy-In file to determine if beneficiaries were actually enrolled.)

These two approaches yield different estimates of the QMB-eligible population. Project HOPE estimates that in 1992 there were 4.67 million eligibles; Families USA estimates 4.25 million -- a difference of 420,000.

The fact that the MCBS and the CPS-SIPP result in different estimates is not altogether surprising. Surveys notoriously have a difficult time trying to estimate

respondents' incomes. The problem is compounded by the target population in this study, because of their age, frail health and generally low education levels. It is difficult to know the "true" incomes of many of these individuals because they often provide incomplete information or do not respond to all questions asked of them.

It is not clear which methodology results in the more accurate estimate. The Families USA study may have introduced error in two ways: first, by using pooled income data from four years of the March CPS; and second, by using SIPP data from 1984 to account for beneficiaries' assets.

The MCBS should result in a more accurate estimate of an eligible population. Unlike the CPS, this survey is focused on the Medicare population. Moreover, the Income and Assets Supplement to the MCBS was designed explicitly to provide comprehensive information on the financial resources of Medicare beneficiaries. Thus, it seems ideal for identifying a low-income population.

However, the Project HOPE methodology may have introduced error as well. The I&A Supplement produced incomplete responses for many individuals; for these individuals, a determination was needed as to whether they were QMB-eligible. This was accomplished by examining their responses on other questions of the MCBS. For example, if respondents provided incomplete information on the I&A Supplement, but had responded elsewhere that they were Medicaid recipients, they were included as a QMB-eligible. For individuals who had not indicated that they received Medicaid (or other public assistance), responses to a different income question (one provided on round 1 of the MCBS) were used to determine eligibility.

On round 1 of the MCBS, fielded in the fall of 1991, respondents were asked whether their incomes fell into categories provided in \$5,000 increments (after an initial probe question asking if their incomes were above or below \$25,000). In addition, on round 6 of the survey, fielded in the summer of 1993, respondents were asked more detailed questions

about income and assets, similar to those asked in round 3 (i.e., the Income and Assets Supplement) but with a yes/no question for each subcategory of income and assets (e.g., income from earnings, interest, etc.) instead of a question asking for an explicit dollar value as on round 3 of the survey. At the end of the probe questions, respondents were asked to state their total incomes, keeping in mind all of their responses to the probe questions. This response yielded an actual dollar total, unlike the round 1 question, which merely provided income in \$5,000 increments.

The initial sample of QMB-eligibles contained many individuals whose incomes on this round 1 question was high; almost 24 percent of the sample reported incomes above \$10,000 on the round 1 question, despite the fact that they had been identified as QMB eligibles on the basis of round 3 questionnaire. As a result, we cross-checked our sample against stated round 6 income. About 10 percent of the sample had incomes above \$10,000 on round 6. Part of the discrepancy might be due to the different time period in which the questions were asked. The round 1 question was asked in the fall of 1991; round 3 in summer 1992; and round 6 in summer 1993. However, it is unlikely that incomes changed so dramatically for this sample during the year and a half. A more plausible explanation is that reported incomes simply vary depending on how questions are framed.

As a result of this data exploration, we removed from the sample respondents with incomes above the poverty line on the round 6 question (\$7,050 for singles and \$9,018 for marrieds in 1993). For the approximately 25 percent of individuals with missing variables on round 6, we used round 1 responses and removed anyone with incomes above \$10,000. This resulted in what we believe is a more accurate sample because everyone in the sample has been identified *twice* as being eligible -- once on the initial round 3 question -- and again, using the round 6 question (adjusted by round 1 for those with missing information on round 6).

A.2 Further Investigation of the CBS Sample

Table A.1 shows a further analysis of the final sample. The table shows that even with this more narrowly drawn sample, some beneficiaries are included who reported high incomes on round 1. The table shows how enrollment rates change if we remove these individuals from the sample. Thus, it provides a good sensitivity analysis. If we remove all respondents with incomes above \$15,000 on round 1, the total eligible population decreases to 4.3 million. Since enrollment rates are lower than average among those removed, the proportion of those enrolled in the remaining sample increases, in this case to 43.9 percent. If we remove all those reporting above \$10,000 on round 1, the eligible population falls to just under 4 million and the proportion enrolled increases to 45.8 percent.

Finally, Table A.2 compares incomes as reported on rounds 1 and 6. Note that all respondents have income below \$10,000 on round 6 (because we removed all those with incomes above this amount). This table shows how reported incomes change depending on how questions are asked (with the caveat as noted above that the time-frame is different). Most beneficiaries reported on round 1 that their incomes were between \$5,000 and \$10,000. Yet the same beneficiaries reported incomes under \$2,000 on round 6.

What can we conclude from these numbers? First, it is difficult to know our population's true income because responses vary considerably depending on how questions are framed. One possibility is that the reported round 1 income is too high -- perhaps because of range bias. That is, that individuals may naturally migrate to a higher category when presented with several categories of \$5,000 increments. Another possibility is that round 3 and round 6 incomes are too low. Respondents may have been reluctant to provide information on income and assets when confronted with detailed questions from an interviewer. Perhaps the questions are threatening or intimidating.

While we don't know which of the two explanations is more accurate, the sensitivity analysis in Table A-1 shows that the final proportions do not change dramatically, even when

all those with high round 1 incomes are removed from the sample. This indicates that our final estimate is probably a reasonable one. Everyone has been identified twice independently as being eligible. Tables A.1 and A.2 show that if there is a bias in our reported enrollment rates, it is probably a slightly downward one. That is, actual enrollment rates might be somewhat higher. This is, of course, only conjecture. It is possible that round 6 incomes are more accurate than round 1 incomes, in which case our eligible population is too small and our enrollment rates too high. This seems unlikely, though, given the problems with incomplete information on rounds 3 and rounds 6, and the higher numbers reported by Families USA in using the CPS.

Even if we adjust for our upward bias and remove all round 1 high income individuals, the percent enrolled only rises to 46 percent. Thus, a generous range for actual enrollment, considering potential downward bias in our study, would be from 40 to 50 percent.

Appendix Table A-1
Analysis of "Low Income" Sample

	Enrolled		Non-Enrolled		Total
	Number	Percent	Number	Percent	
	(in millions)				
Income (Round 1)					
\$ 0 - 4,999	.779		.711		1.489
5,000 - 9,999	.939		1.230		2.163
10,000 - 14,999	.081		.274		.356
15,000 - 19,999	.007		.116		.124
20,000 - 24,999	.002		.084		.086
25,000 - 29,999	.004		.044		.047
30,000 - 34,999	.000		.011		.011
35,000 - 39,999	.000		.015		.015
40,000 - 44,999	.000		.008		.088
45,000 - 49,999	.004		.012		.016
	.005		.015		.019
Total Sample	1.930	41.3%	2.741	58.7%	4.671
Total Sample	1.908	43.9%	2.436	56.1%	4.344
Incomes Above \$15,000	1.827	45.8%	2.162	54.2%	3.989
Incomes Above \$10,000					

Appendix Table A-2
Further Analysis of Round 1 and Round 6 Income

CBS Round 1 Income (\$)								Total	
<5K	5K-10K	10K-15K	15K-20K	20K-25K	25K-30K	30K +			
(in millions)									
CBS Round 6									
Income (\$)									
>2K	1.05	1.74	.30	.10	.05	.04	.03	3.31	
2K - 4K	.02	.02	.00	.21	.00	.00	.01	.27	
4K - 6K	.13	.11	.01	.00	.01	.00	.00	.25	
6K - 8K	.02	.10	.01	.00	.00	.00	.00	.13	
8K - 10K	.00	.02	.01	.00	.00	.00	.00	.03	
Total	1.22	1.99	.03	.31	.06	.04	.04	4.00	

APPENDIX B
TECHNICAL ADVISORY PANEL MEMBERS

Meeting 1: April 28, 1992

Jay Sternberg, Senior Program Specialist
Consumer Affairs
American Association of retired Persons
Washington, DC

Lourdes Olivas
Consumer Affairs
American Association of Retired Persons
Washington, DC

Phyllis Torda
Director of Health and Social Policy
Families USA Foundation
Washington, DC

Larry Rickards
Assistant Director
National Association of Area Agencies on Aging
Washington, DC

Diane Justice
Deputy Director
National Association of State Units on Aging
Washington, DC

Joan A. Kuriansky
Executive Director
The Older Women's League
Washington, DC

Share Decroix Bane
Director
University of Missouri-Kansas City
Center on Aging Studies
National Resource Center for Rural Aging
Kansas City, MO

Jane Horvath
Director of Health Policy Unit
American Public Welfare Association
Washington, DC

Clarence Murray
Project Director
The National Black Caucus and
Center on Black Aged, Inc.

Michell Rinaldi
Management Intern
National Hispanic Council on Aging
Washington, DC

Other Attendees

Staff from Project HOPE Center for Health Affairs

Robyn I. Stone
Senior Policy Analyst

Marc L. Berk
Deputy Director

Robert Friedland
Senior Policy Analyst

Leigh Ann White
Research Assistant

Staff from Health Care Financing Administration

Carl Josephson
Director of Division of Program Studies
Office of Research and Demonstrations

Feather Davis
Social Science Research Analyst
Office of Research and Demonstrations
Division of Program Studies

Carolyn Rimes
Survey Statistician
Division of Survey Analysis
Office of National Health Statistics
Baltimore, MD

Staff from Westat, Inc.

Brad Edwards
Associate Director

Meeting 2: July 7, 1994

Jay Sternberg
Senior Program Specialist
Consumer Affairs
American Association of Retired Persons
Washington, DC

Phyllis Torda
Director of Health and Social Policy
Families USA Foundation
Washington, DC

Adina Robertson
Community Education Coordinator
Legal Services of Middle Tennessee
Nashville, TN

Lee Partridge
Director
Health Policy Unit
American Public Welfare Association
Washington, DC

Serafina Clarke
Field Representative
Nutrition Consortium of New York State
Albany, NY 12210

Larry Crecy
Executive Vice President
The National Black Caucus and Center on Black Aged, Inc.
Washington, DC

Jeff Finn
Executive Director
The SPRY Foundation
Washington, DC

Other Attendees

Staff from Project HOPE Center for Health Affairs

Peter Neumann
Senior Research Director

Gail Wilensky
Senior Fellow

William Evans
Senior Research Associate

Marc L. Berk
Director

Mimi Bernardin
Policy Analyst

Ellen Bayer
Policy Analyst

CMS LIBRARY



3 8095 00005938 2